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ABSTRACT

This training manual for personnel who work with older adults is designed to create awareness and knowledge of health maintenance for older Americans. Increasing awareness of the health needs of the aging, and fostering understanding of biological, psychological, and sociological aging processes, and of positive attitudes toward health care and protection of the aged, are covered in the initial sessions. An awareness of housing problems, how these problems affect health maintenance, the relationships between environmental safety and leisure activity with health maintenance, and geriatric nutrition needs are also stressed. Finally, an understanding of the older person's view of death is fostered. Step-by-step instructions for procedures and objectives are included. A list of materials needed for each session is also included, along with a resource directory for obtaining films which are recommended for use in several sessions. (Author/MBR)

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MAINTAINING GOOD HEALTH IN LATE LIFE

A Training Manual

developed for

The N. C. Governor's Coordinating Council On Aging

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TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC) AND USERS OF THE ERIC SYSTEM."

Lawrence P. Benson

I2006694

Extension Division
The University of North Carolina
Chapel Hill

1975

NOTES TO THE INSTRUCTOR

This curriculum has been developed in such a manner so as to reduce significantly your personal preparation time in comparison with usual lesson plans, subject matter knowledge and pedagogical background. In fact, you could instruct these sessions with no prior reading in the gerontological field other than the lesson plans contained in this manual. They contain step-by-step instructions and the subject matter itself; the timing of class breaks is left to your discretion. However, both you and the seminar participants will benefit if you do some reading in the field prior to each session, and we strongly so advise it.

In particular, we strongly suggest that you read the four volume pamphlet series, Working With Older People: A Guide to Practice.

Vol. 1: The Practitioner and the Elderly
Vol. 2: Biological, Psychological and Sociological Aspects of Aging
Vol. 3: The Aging Person: Needs and Services
Vol. 4: Clinical Aspects of Aging

The series is published by the Department of Health, Education and Welfare, Public Health Service, and is for sale from the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402, for $1.00 each. Order PHS Pub. No. 1459. Other references are listed later in these notes.

We also suggest that you read through this manual at least once before preparing for each session. You will note that the first page of each session lists the purpose of the session, the learning objectives for it, the approximate time required to conduct the session, and the materials required during the session. You will want to arrange for these materials well before each particular session, especially when ordering the films (which play an extremely important role in the learning design of this curriculum). You should allow six (6) weeks of order time prior to the showing of each film, perhaps four (4) weeks in local instances.

Prior to each session

In preparation for each session, we suggest that you spend about one to two hours accomplishing the following items:

1. Read through the Lesson Plan twice, underlining, making marginal notes, and otherwise personalizing the Plan.

2. Insure that the materials required are ready for use.

3. Do some background reading in the area of the session from the Working With Older People series or other materials.

Films and Film Strips

The following movies are to be shown during the course of the eight sessions. The procurement code letter(s) following the title indicate where you can secure a copy of the film.

Session 1 - The Wrinkle Squad (C)

Session 2 - Perspectives on Aging series (A), (D)
Program 2 - Physical Changes and Their Implications
Program 3 - Implications for Teaching

Session 3 - Seasons (A), (E), (F)

Session 4 - Step Aside/Step Down (A), (E), (F)

Session 5 - Now Is Forever (G)

Session 6 - none

Session 7 - The Art of Age (A), (B), (H), (I), (J)
Rescue from Isolation (K), (L)

Session 8 - Until I Die (A), (M)
The Family of Man: Old Age (N)

Procurement Codes

(A) Center for the Study of
Aging and Human Development
Duke University Medical Center
P. O. Box 3003
Durham, N. C. 27710
(919) 684-3654

A handling charge of $5.00
should accompany the request.

(B) Loan from:
North Carolina Public Library
Film Service
Audio Visual Center
101 East Jones Street
Raleigh, N. C. 27602

(C) For sale at cost of $135 from:
Paulist Productions
P. O. Box 1057
Pacific Palisades, CA 90272

(D) Complete series of five film
strips for sale $252 (records)
or $267 (cassettes) from:
Concept Media
1500 Adams Avenue
Costa Mesa, CA 92629

(E) For sale $68 or rent $10 for
three days from:
Distribution Branch
National Audiovisual Center (GSA)
National Archives and Records
Service
Washington, D. C. 20409

(F) For rent $3.50 for 3 days from:
Iowa State University
Media Resource Center
121 Pearson Hall
Ames, Iowa 50010

(G) For sale $500 or rent $50 per day
from:
Film Dynamics
7250 Fair Oaks Blvd.
Carmichael, CA 95608

(H) For sale $325 from:
ACI Productions
11th Floor
35 West 45th Street
New York, New York 10036

(I) For rent at $12 from:
University of Illinois
Visual Aids Service
1325 South Oak Street
Champaign, Illinois 61820

(J) Loan from:
Los Angeles Public Library
Audio-Visual Department
630 West Fifth Street
Los Angeles, California 90017

(K) For rent $7.50 from:
Canadian Film Institute
1762 Carling
Ottowa, Ontario K2A 2H7

OR

Malmonides Hospital & Home
for the Aged
5792 Caldwell Avenue
Montreal, Canada H4W 1W3

(L) For sale $400 or rent $20 from:
Transit Media, Inc.
779 Susquehanna Avenue
P. O. Box 315
Franklin Lakes, N. J. 17417

(M) For sale $240 from:
Video Nursing, Inc.
2834 Central Street
Evanston, Illinois 60436

(N) For sale from:
Time-Life Films
100 Eisenhower Drive
Paramus, N. J. 07652

Remember, a film is only a part of this communication and this learning experience. It is what you do to prepare people for the viewing experience that is important. Thus, it would be advisable for you to preview each film before the class session. Even more important are the follow-up activities. A good film (and those of this curriculum are excellent) serves as a stimulus to seek still more information. It is a tool for provoking a sharing of experience and ideas. A film can inform, but it can also sensitize the viewer to a condition or an issue. This sensitization, a goal of this seminar series, is the first step toward expanding awareness, increasing knowledge, and instigating action.

With regard to the 16mm film projector, screen, and the 35mm film strip projector required in Session Two, you may want to rent these items from a local camera store if none are available on loan in your organization.

Handouts - Information Sheets

Most every session requires Information Sheets to be reproduced and distributed to the participants. We suggest that they be copied on an office copier well before the session of their use. They are a very important part of the learning design of this curriculum.

Other Materials

You should make good use of a blackboard (with chalk and eraser, of course) or paper flip charts on an easel and felt pens. Each session lesson plan will require you to use the blackboard rather extensively. It also is an important part of the design of this curriculum in that its use visually reinforces the points you or the participants make verbally.

In addition, the last section of this manual contains bibliographic and information source materials. You may wish to distribute this section to workshop participants at the first session.

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INTRODUCTION

PURPOSE: To develop in the participant an increased awareness and a heightened understanding of the aging American and his health needs.

OBJECTIVES: At the end of this session, each participant will be able to:

1. Identify the instructor and other course participants. (10 Minutes)
2. Know and understand the purpose and objectives of the course. (15 Minutes)
3. Distinguish reality from commonly held myths about aging and the older person. (30 Minutes)
4. Identify some of the common problems of the aged, and some general alternatives to growing old in silence. (50 Minutes)

TIME: About 1 3/4 Hours.

MATERIALS NEEDED:

A. Handouts
   1. Information Sheet 1
   2. Information Sheet 2

B. Flackboard, or flip chart and felt pens.

C. 16 mm Film Projector
   Movie Screen
   Movie: "The Wrinkle Squad"
   28 min., B & W, 1971

OBJECTIVE	PROCEDURE
1. Identify the instructor and other course participants.	Hello and welcome to this seminar entitled "Maintaining Good Health in Late Life". I am as pleased that you are here as I am delighted to be here with you. Before we proceed any further, though, I think it is important for all of us to know each other. I will lead off. My name is _____(give employment, a thumbnail sketch of previous experience, and some personal notes about what kinds of things are important to you. Then have the participants do the same).
2. Know and understand the purpose and objectives of the course.	Let's take a little closer look at the course title. (Write title on blackboard and underline "Health". Ask a few participants for their definition of the underlined terms. When they have commented, pass out Info Sheet 1, the definition of Health by the World Health Organization, and give them two or three minutes to read it). What does W.H.O. specify to be included in the term, health? (Once you have elicited the idea of health comparing the physical, psychological, and social well-being of an individual, move on). What are some broad kinds of things that bear upon or make up the concept of maintaining good health? (List the responses on the blackboard. You want to list at least the following items; add those that are not mentioned). -- Physical function -- Psychological function -- Sociological function -- Finances or Income -- Housing -- Environmental Safety -- Food or Nutrition -- Leisure activity -- Concept of facing death

(Place an "X" on the blackboard beside all items which correspond to the above list).

The objectives of this seminar are to:

1. Help you to understand the process of aging.

2. Develop insights into the problems that may come with aging.

3. Suggest some alternative resources in the community and state through which you can make referrals for problems that may arise in your work with the aging.

In order to make the sessions of this seminar more vivid and interesting for you, we will take a rather different methodological approach to it. We will be using a number of films in the presentation of the material to be covered. I will preface each film by some comments on what you will be seeing and what concepts in the film I will want you to notice. I strongly urge you to make notes of these concepts and your questions during the film. In that way we all will benefit and grow from this seminar. Incidently, your questions are always welcome. In my opinion, the only "dumb question" is the one that is not asked.

The Process of Aging

There is no one single definitive process of aging that is all encompassing. In actuality, there are three processes that occur at different rates in different people. Those three are a biological or physical process, a psychological process and a sociological process. And yet, they are all enmeshed and intertwined with each other. During the remainder of this session we will deal with the biological process of aging and some of the more common myths surrounding the natural processes of aging. One major caveat I wish to make at this point is: Every person, aged or young is a truly unique individual. Therefore, it is extremely important for us as toilers in the vineyard of the aging to deal with individuals, not groups or stereotypes. This caveat will become more and more apparent throughout the course of this seminar.

3. Distinguish reality from commonly held myth about aging and the aged.

The Problem of Perspective

For those of use who work in the field of aging, it is very difficult to obtain and maintain a balanced perspective on aging and the aged. If we work in nursing homes or other kinds of institutions and deal only with older persons who live in institutions, we may be likely to think that most older persons are like institutionalized older persons. If we are psychiatrists who see only older persons who have emotional problems, we are likely to think that most older persons are depressed or hypochrondriacal. If we are social workers who certify older persons for food stamps, we are likely to think that most older persons are in need of financial support. In general, our view of what older persons are like is heavily influenced by the kind of older persons with whom we are most familiar.

While we may have a very accurate picture of the older persons with whom we deal, it is necessarily an incomplete or limited picture. Also, because we tend to deal only with older persons who have various kinds of problems, it is very easy and very natural to suppose that most older persons have pretty much the same kinds of problems: lack of income, loneliness, and families who don't care about them, to mention but a few.

However, when a large, representative sample of older persons is studied or when data are gathered for older persons as a whole, a different and brighter picture emerges. The majority of older persons, at least 70 percent, are in pretty good shape in terms of such factors as income, health, and social integration. This is a reassuring statement, but it may seem to contradict your experience with older persons. Actually, however, there is no contradiction. While most older persons may not have a problem which they cannot handle, about 30 percent of them do -- and it is with this 30 percent, or roughly seven million persons, that we do most of our work. In other words, while we need not worry about the well-being of most persons, we still have plenty with whom we must be concerned. With this thought in mind, let us turn to some of the more common misconceptions about older people. (Pass out Info Sheet 2).

Myth #1: "Most older persons are living in poverty."

Reality: In 1972, some 3.7 million, or about 1/5th of the elderly, lived in households with incomes below the official poverty threshold for that kind of household. This considerable improvement over the close to 5 million in 1970 results from increases in social security benefits. Women and minority aged are over-represented among the aged poor. Many of the aged poor became poor after reaching old age because of the cut in income brought by retirement from the labor force.

Myth #2: "Occupational retirement has generally negative consequences for older persons".

Reality: There is a little evidence that retirement, per se, has any necessary relationship to problems frequently found among individual older people. Certainly the most common effect of retirement is the limitation it places on income. It is the sharp loss of income and the change in lifestyle associated with it that has the most significant influence on the individual. Some research has found that retirement as such had little influence on variables such as depression, anxiety, anomie, or self stability.

Myth #3 "People are living longer than ever before".

Reality: It is not true that people are living longer than ever before. The life span of human beings or the maximum length of time that people can live is about 110 years and has probably never changed. Throughout history, a few people have lived to be very old, but now more and more persons are living into old age. In the United States, life expectancy, or the average length of time that people live, has been increasing and is now about 71.2 years; 67.4 for men, but close to 8 years longer or 75.2 years for women. At age 65, average remaining years of life were 15.3; 13.1 for men, but 4 years longer or 17.2 for women.

Myth #4: "Most older persons would like to live with their children".

Reality: Most older persons (about 70 percent) live in their own homes and prefer it this way. About 20 percent of older persons live with their children, but this seems to be based more on economic necessity than choice.

Myth #5: "Most older persons want to continue to work".

Reality: Cross cultural studies have indicated that, when given a choice, substantial proportions of the elderly choose not to continue working. An exception has been noted with active men, particularly among the recently retired, who express desires to continue to work.

Myth #6: "Most older persons are socially isolated".

Reality: Only a very small minority (4 percent or fewer) live in extreme isolation in the sense that a week or even a day can pass without human contact. Few people lack meaningful everyday relationships and social activities.

Myth #7: "Most older persons are lonely".

Reality: Only a minority of the elderly say they are often or sometimes lonely, varying from 17 percent in Denmark to 28 percent in Britain and 30 percent in the United States.

Myth #8: "Families are quick to place their older members in institutions such as nursing homes and state hospitals".

Reality: In general, families have very negative attitudes toward institutions of all kinds and are reluctant to place older members in them. Usually, families turn to institutionalization only as a last resort.

Myth #9: "The older population has increased at approximately the same rate of growth as the remaining population".

Reality: In 1900, with a population of 76 million, the aged composed 3 million or about 4 percent. Today there are 200 million - 20 million aged - slightly more than 10 percent. While the total population has approximately tripled during the past 70 years, the aged segment of the population increased seven fold. The aged are more numerous - more visible, etc. We should talk about quality of life for aged, not quantity.

Myth #10: "Biologically a person can be considered old when he is 65 years".

Reality: Being old is a subjective fact as well as a biological one; to the 20 year old, 30 is old. Being old has a social definition. It also has an economic confinement; a boxer is old at 40. Self-definition is important. The variable of race and lower life expectancy of black, for example, is a limiting factor.

Myth #11: "The medical needs of all those who are 65 and over are about the same".

Reality: The medical care needs of the 73 and over group are 3 times the 65-72 group. The fact that half the older population today is 73 and over has profound implications for long-term institutional care. Half of those who are in nursing homes and homes for the aged are over 80. They are usually poor, have impaired mental and physical functioning, multiple chronic disabilities and lack families. Introduce the idea of non-institutional settings. How many of those in long term institutional care could be rehabilitated if there were non-institutional settings where they could live and receive the services they need?

Myth #12: "The life expectancy of a 65 year old male has increased dramatically since 1900".

Reality: There has been an improvement in life expectancy of only 2 years to 13 years today. In 1900 it was 11 years. Life expectancy at birth has increased dramatically because of the reduction of infant mortality and the cure and elimination of childhood diseases. In

medieval Europe, the life expectancy was estimated at 30 years. There has also been a greater improvement in life expectancy for women 65 years of age - 17 years in 1970 - 12 years in 1900.

Myth #13: "There are twice as many women as men who are 65 and over".

Reality: In 1970 there were 138.5 women 65 and over for every 100 older men. For those 75 and over, there were 156 females for every 100 males.

Myth #14: "The U. S. spends a larger percentage of its Gross National Product (GNP) for the aged than any other country in the world".

Reality: Some countries in Western Europe, for instance, Holland and Belgium, spend a larger portion of their G.N.P. for older people.

Myth #15: "Most people who choose early retirement cite sufficient income and desire for travel as the most frequent reasons".

Reality: The most prevalent reason for early retirement is poor health. The percentage who choose early retirement citing poor health varies by country; in the U. S. it is about 65 percent, in Denmark 76 percent, in Great Britain 56 percent, and in Poland 38 percent. At this point the trainer may wish to point out that the incidence of illness may be related to a search for a legitimate release from the Protestant work ethic. In other words, it is not acceptable to lay out of work, but it is acceptable to miss work for illness.

One needs also to consider the economic factor existing in the relationship between poor health and early retirement. Social security benefits are greater when illness can be cited as a factor for early retirement.

Myth #16: "Not having many social contacts decreases the morale of the elderly".

Reality: Not necessarily. The number of social contacts is not as important as the quality of the contact. The crucial variable is the maintenance of a stable, intimate relationship with another individual. A confidant relationship is more highly associated with good morale and good mental health than is a high level of social intimates. The need for intimacy lasts throughout life at all ages. We all have need for supportive roles - primary relatives, the need to confide, ventilate, be touched, etc.

Myth #17: "There is no difference in frequency of confidant relations between social classes".

Reality: White collar persons have confidant involvements more frequently than blue collar workers. Introduce or reintroduce the need to qualify - sensitize people to variables such as race, age, education, and income (socio-economic status). For example, married people more than single people develop such intimate confidant relations. The death of a spouse is the greatest single stress an individual can experience.

Myth #18: "Most illnesses of the aged can be cured".

Reality: Of those 65 and over, three-fourths have some chronic illness and must learn to deal with this handicap. Most elderly cope quite well in spite of these chronic illnesses, which should be defined as old age rather than illnesses. The aged do not regard it as a functional handicap unless it is quite severe. Older people often have a more realistic concept of health than those serving them. They see health in terms of functions.

Myth #19: "Organic mental disorders occur to about half of those 65 and over".

Reality: Although the percentage of psychoses and organic mental disorders rise with advancing age, the estimates of the evidence of mental impairment vary from 10 percent to 25 percent. Although it can happen, it is not inevitable. It is estimated that the majority of elderly

patients who require emergency psychiatric care are also seriously in need of general medical treatment as well. For instance, when a 65 or 75 year old becomes dehydrated, he hallucinates. Some chemicals taken can induce psychotic or abnormal manifestations.

Myth #20: "Old age is a dysfunctional decline".

Reality: Old age is a developmental process, a continuum.

Myth #21: "Senility is biologically determined and inevitable".

Reality: Confusion, memory loss, and associated disorganization are not directly attributable to physical causes. Senility is a waste basket term for illnesses which are not inevitable or genetic. There are probably multiple causations such as sensory deprivation, chronic depression, and medications. Implications: Much can be reversed.

Myth #22: "Older workers just aren't motivated".

Reality: The worker must be evaluated in terms of his expectations and values. The older worker's hierarchy of needs and values may be different regards. Implications: Listen to the frame of reference - where he or she is coming from.

Myth #23: "The elderly talk too much and live too much in the past".

Reality: "Life Review" is a process to be respected. It is a quest for meaning, for finishing "unfinished business" of the past.

Myth #24: "IQ declines with age".

Reality: This is not true.

Myth #25: "Old people are asexual".

Reality: Not true.

Myth #26: "Old people are like children".

Reality: Not true.

Myth #27: "Self worth declines with age".

Reality: Self image may be modified by such things as mobility, lower socio-economic level, loss of sex-linked roles, poor health, lessened human contact, loss of vocation and avocation, but in general, findings are that older persons tend to become "more like themselves", less subject to role models from others. Implications: to build autonomy, independence.

Myth #28: (negative stereotype) "Old people are: inherently more fearful, anxious, depressed, inherently hard to please, pretty stubborn, incapable of making significant decisions for themselves, miserable, expect everyone to pamper them, often grouchy, lacking in poise and grooming, and don't appreciate what is done for them".

Reality: Emotional reactions to stress, rather than the inherent process of aging cause such personal problems. Loneliness is related to social loss. Of crucial importance: spouse, child, sibling, grandchild, friend, deprivation of contact and meaningful others. Implications for workers: to help persons rebuild contacts. Depression, and even death is associated with helplessness. Implications for workers: preservation of options, rebuilding of autonomy and selfhood.

Myth #29: "As you get older you get more religious".

Reality: Studies show that older people are no more religious than younger people.

Myth #30: "The suicide rate for persons age 75 and over is about the same as for those age 18-25".

Reality: In fact, the rate for age 75 and over is almost eight times greater and comprises some 25 percent of all suicides.

Now that we have dispelled some of the incorrect stereotypes and misconceptions of the aged population, we have a clear foundation upon which

to build health maintenance guidelines. We will look at the three aging processes in the next session in more detail.

4. To identify some of the common problems of the aged, and some general alternatives to growing old in silence.

However, let's look at some of the problems of aging, using a movie entitled, "The Wrinkle Squad" as a vehicle. I urge you to take notes during the film and look for the following:

1. What problems fell upon each character in the movie?

2. What alternatives did he choose to solve the problems?

(Start film) "The Wrinkle Squad", 28 minutes, B & W

(Upon completion, ask individual participants for their synopsis of each man's problems. Do the same for the alternative solutions. Then ask,)

What are the relevant caveats for the aged underlying the situation depicted in this film?

(Answer: 1. A need for senior citizens to keep actively involved in life.

2. To make themselves heard.

3. To not be manipulated into a stupor by insensitive bureaucracy.)

The next session for this seminar will be held on _____(day) at _____o'clock at _____(location).

See you then and thank you for coming today.

Excerpt from the CONSTITUTION OF THE WORLD HEALTH ORGANIZATION

The States parties to this Constitution declare, in conformity with the Charter of the United Nations, that the following principles are basic to the happiness, harmonious relations and security of all peoples:

Health is a state of complete physical, mental or social well-being and not merely the absence of disease or infirmity.

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.

The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest cooperation of individuals and States.

The achievement of any State in the promotion and protection of health is of value to all.

Unequal development in different countries in the promotion of health and control of disease, especially communicable disease, is a common danger.

Health development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development.

The extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health.

Informed opinion and active cooperation on the part of the public are of the utmost importance in the improvement of the health of people.

Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures.

Drafted June - July 1946

MYTHS AND REALITY

1. "Most older persons are living in poverty".
2. "Occupational retirement has generally negative consequences for older persons".
3. "People are living longer than ever before".
4. "Most older persons would like to live with their children".
5. "Most older persons want to continue to work".
6. "Most older persons are socially isolated".
7. "Most older persons are lonely".
8. "Families are quick to place their older members in institutions such as nursing homes and state hospitals".
9. "The older population has increased at approximately the same rate of growth as the remaining population".
10. "Biologically a person can be considered old when he is 65 years".
11. "The medical care needs of all those who are over 65 are about the same".
12. "The life expectancy of a 65 year old male has increased dramatically since 1900".
13. "There are twice as many women as men who are 65 and over".
14. "The U. S. spends a larger percentage of its Gross National Product (GNP) for the aged than any other country in the world".
15. "Most people who choose early retirement cite sufficient income and desire for travel as the most frequent reasons".
16. "Not having many social contacts decreases the morale of the elderly".
17. "There is no difference in frequency of confidant relations between social classes".
18. "Most illnesses of the aged can be cured".
19. "Organic mental disorders occur to about half of those over 65".
20. "Old age is a dysfunctional decline".
21. "Senility is biologically determined and inevitable".
22. "Old workers just aren't motivated".
23. "The elderly talk too much and live too much in the past".

24. "IQ declines with age".

25. "Old people are asexual".

26. "Old people are like children".

27. "Self worth declines with age".

28. "Old people are inherently more fearful, anxious, depressed, inherently hard to please, stubborn, incapable of making significant decisions for themselves, miserable, expect everyone to pamper them, often grouchy, lacking poise and grooming, and don't appreciate what is done for them".

29. "As you get older you get more religious".

30. "The suicide rate for persons over 75 is about the same as for those age 18-25".

These foregoing statements are <u>all</u> predominently <u>false</u>!

SESSION TWO

BIOLOGICAL, PSYCHOLOGICAL AND SOCIOLOGICAL ASPECTS OF AGING

PURPOSE: To develop an understanding of the natural biological, psychological and sociological aging processes, and their complex relationship.

OBJECTIVES: At the end of this session, the participant will be able to:

1. Identify normal physical changes which alter body systems, and their affect on functioning of the elderly. (60 minutes).
2. Discuss the implications of the three aging process changes for the participant's work situacion. (45 minutes)

TIME: About 1½ hours.

MATERIAL NEEDED:

A. Film strips from the "Perspectives on Aging" series:
   Program 2 - "Physical Changes and Their Implications"
   Program 3 - "Implications for Teaching"

B. 35 mm Film Strip Projector
   Of the many models available, the instructor can choose to use one with a record turntable or a tape cassette deck. Second, the cassettes or records can be played on standard machines while the film strip is advanced manually. Third, the instructor can narrate the film strip using the Instructions Manual accompanying the series.

C. Blackboard or flip charts with felt pens.

SESSION TWO
BIOLOGICAL, PSYCHOLOGICAL
AND SOCIOLOGICAL ASPECTS
OF AGING

OBJECTIVE

PROCEDURES

Hello again and welcome back to this set of seminars entitled "Maintaining Good Health in Late Life". You may recall that during our last session, we introduced the subject of aging and health, principally by separating commonly held myths from reality. We are now in a position to build upon an uncluttered foundation our knowledge of the three simultaneous processes in aging, biological or physical, psychological, and sociological.

Before we proceed with today's material, though, I would like to give you an opportunity to ask any questions that may have come to mind since Session One.

(Give the participants about 5 minutes to ask questions.)

I would like to pose a question to you. We discussed some caveats during the last session regarding aging individuals. What, in your opinion, is the most important factor in working with the aging?

(ANSWER: The response you should try to elicit is that both rate and extent of the aging process varies by individual. Therefore, the most important factor in dealing with the aging is the participant's attitudes and treatment of the elderly as a truly unique person with value to himself and society.)

Today, we are going to delve into the 3 processes of aging in greater detail. Those processes or aspects are:

1. Biological or physical change
2. Psychological change
3. Sociological change

The objective of this session includes:

1. Your ability to identify normal physical changes which alter body systems, and their effect on the functioning of the elderly.
2. Your ability to discuss from a factual basis the changes that occur due to these three aging processes and their implications to your personal work situation with the aging.

There exists no experience in our American culture which is more denied, consciously or unconsciously, by so many people than the phenomenon of growing old. Probably not even death. With death, there is a very definite time demarcation; one is either alive or dead. Old age is much different. It is a continuum of experiences, not a single experience.

Our culture values highly, perhaps exaggerates, and emphasizes youth and work. Aging is the antithesis of these values and thus the denial of aging is understandable in terms of societal norms.

Another important set of reasons for denial of the aging process are those changes taking place in the structures of family and society. The grandparent as a member of the same familial household, a multi-generation family if you will, is changing.

For these reasons and many others, despite scientific advances, the truth about aging is distorted by false information and misconception. And yet, I submit that our personal views of aging and old age may very well determine whether or not we can make a contribution toward a better life for the elderly.

Biological Aspects of Aging

1. Identify normal physical changes which alter body systems, and their affect on functioning of the elderly.

Physical changes which alter body systems in the process of growing old begin at conception and terminate at death. These normal age-related changes affect in each of us, young or old, our ability to function in our daily lives.

We are going to view a film strip entitled "Physical Changes and Their Implications".

During the film strip, I would like you to make notes in answer to the following questions: (Write on the blackboard).

1. Name the physical changes that occur in aging and indicate which you think are inevitable.

2. Which body systems are affected by change? Which have the greatest effect on daily function?

3. What is your advice for a long, healthy life?

(Start the film strip, Program 2 - "Physical Changes and Their Implications". If the instructor chooses his own narration for the film strip, turn to page 25 of the Instructor Manual for the series: read pp. 25-36).

(At the end of the film strip, repeat the questions individually for participant discussion).

Psychological and Sociological Aspects of Aging

2. Discuss the implications of the three aging process changes for the participant's work situation.

In addition to biological change in body systems, psychological and sociological changes occur which, and I stress, are a natural part of growing older. These changes also have an affect on the aged's ability to function in his or her daily life. More importantly for us who choose to work with the aging, these changes imply techniques and methods which we can use in our work experiences to enhance our individual contributions to the elderly client.

The film strip we are about to see is entitled "Implications for Teaching". It surveys the three aging processes which influence the aging and affects their learning. Although this strip is specifically aimed at health care personnel who teach the aged, the concepts and techniques presented can help us to maximize the benefits of our work with the aging.

I urge you once again to take copious notes during this film strip, particularly in regard to the following questions which we will discuss at the conclusion of the strip:
(Write on the blackboard).

1. What are the psychological changes that occur during aging?

2. What are the sociological changes that occur?

3. Which of these changes affect our dealings with elderly clients in our work environment?

4. Which techniques presented here can you implement in your work situation?

(Start the film strip, Program 3 - "Implications for Teaching". If the instructor chooses his own voice over the film strip, turn to page 45 of the Instructor's Manual for the series; read pp. 45-55).

(At the end of the film strip, repeat the questions for participant discussion).

This session concludes the material in this seminar on the conceptual bases of the aged and the processes of growing old. You have no doubt seen in this material a wealth of implications for the maintenance of good health while growing old. I would like to highlight once again that aging is a very individual process. It is as wrong to draw parallels between a 65 year old and a 95 year old as it is to draw conclusions about behavior between a 35 year old and a 5 year old.

In the remaining sessions of the seminar, we will begin to identify more specific health problems that occur in late life and resources upon which we can draw for solutions, referral, and continued identification.

Session Three will be held on _____(day) at _____(location) at _____(time). Thank you for coming and I will look forward to our next session.

SESSION THREE

HEALTH PROTECTION AND SERVICES

PURPOSE: To develop within each participant an understanding of and positive attitude toward health care and protection of the aging individual.

OBJECTIVE: At the completion of this session, the participant will be able to:

1. Define the term "health" for the aged. (20 minutes)
2. Name the three leading causes of death in the aged population. (5 minutes)
3. Names the three leading causes of disability in the aged population. (10 minutes)
4. Identify some types of health services generally available to the aging. (20 minutes)
5. Identify at least five elements in the environment which can directly effect health maintenance or protection of the elderly. (30 minutes)
6. Discuss five basic principles of health management. (30 minutes)

TIME: About 2 hours.

MATERIAL NEEDED:

A. Handouts
   1. Information Sheet #3, "Tables of Death and Disability"
   2. Information Sheet #4, "Types of Health Services"
   3. Information Sheet #5, "Principles of Management"

B. 16 mm Film Projector

C. Film, "Seasons", 16 minutes, color.

D. Blackboard or flip charts with felt pens.

SESSION THREE
HEALTH PROTECTION AND
SERVICES

OBJECTIVE

PROCEDURES

Welcome back to the seminar, "Maintaining Good Health in Late Life". Today's session is called "Health Protection and Services" and will serve to increase our awareness of health protection, its meaning, health services, and their availability to the aging community. Before we proceed, I would like to give you the opportunity to raise questions which have resulted from the last session. (Allow about 10 minutes for questions).

The objectives for this session are multiple. They are to enhance:

1. Your ability to define the term "health" as it relates to the aged.

2. Your ability to name the 3 leading causes of death and disability in the over 65 population.

3. Your ability to identify general types of health services generally available.

4. Your ability to discuss the principles of health management.

5. Your ability to identify at least five environmental elements or factors which can directly affect health maintenance of the elderly.

Health: A Definition

1. Define the term "health" for the aged.

While the over 65 generation is not as healt as the young, most are, for all practical pu ses, quite healthy and are likely to maintain th state of health until very near the end. Many me ers of the helping professions find this statement difficult to accept.

Some reject the claim because they themselves are illness-oriented. They define health as the absence of clinical pathology. Seen this way, old people are indeed sick, and the older they get the sicker they become. Eighty-six percent of persons over 65 have at least 1 chronic condition.

When one adds acute illness and accidental injuries, practically every old person has something wrong with him.

Other professional workers reject the statement because it contradicts their own experience. Most of the aged persons whom they are trying to help are ill, frail, disabled or dependent. They assume their clients are typical of old people, but in reality they are atypical. The old do not usually turn to community agencies for help until they, their families and friends can no longer cope with a problem. By that time, the problem is serious and complicated.

Henceforth, we will use the following definition of "health" in this seminar. (Write on the blackboard).

HEALTH: the ability to function well enough to carry out normal roles and responsibilities in the community.

This definition has a number of advantages to us in the helping professions and to the aging themselves. What advantages can you think of?

(Answer:)

1. It is relatively easy to determine how well people are functioning.

2. It directs attention to conditions within the individual or environment which, when connected, will improve functions.

3. It makes sense to the aged themselves as well as to professionals.

Health Status of Old People

In terms of our definition then, old people seem to be pretty healthy. The National Center for Health Statistics indicates that:

-- only 5% of persons over 65 are so ill or function so poorly that they must live in nursing homes or other institutions.

-- even at age 85, only 8 out of 10 persons are living in their own or relative's homes and not in institutions.

But how well do the noninstitutionalized aged function? Chronic or long-term conditions are the major source of disability for old persons, and 85 percent report at least one chronic condition. Yet only 14 percent of the

noninstitutionalized aged report that they are totally unable to work or keep house due to a chronic condition. An additional 25 percent can work but are somewhat limited in the amount or kind of work or house work they can undertake. Even at age 75, only 24 percent are totally limited and 30 percent partially limited in work capacity because of chronic illness.

One additional measure of health is the number of days per week in which the person has restricted activity or is confined to bed. This measure of "disability days" counts all such days, whether due to chronic illness, acute illness or accidents. National Center for Health Statistics data indicates that old people have more disability days than young or middle aged people. But even the old are, on the average, restricted in activity only 35 days per year and are confined to bed on only 12 of these days.

Despite this encouraging view of the health of the aged, there are aging process realities to be considered.

Major Health Problems

2. Name the 3 leading causes of death in the aged population.

Two types of health problems are considered here, namely, the main causes of health and disability and the bariers which stand in the way of maintenance of health and control of illness. (Pass out Info Sheet #3).

Three-fourths of all deaths among persons over 65 are due to heart disease, stroke and cancer. Diseases of the heart are by far the most important cause of death. Within this category, arteriosclerotic heart disease (including coronary heart disease), claims the greatest number of victims. Table 1 on Info Sheet #3 lists the leading causes.

3. Name the 3 leading causes of disability in the aged population.

Now look at Table 2 on your Info Sheet. Heart conditions and arthritis and rheumatism cause the greatest amount of disability.

Further, on any given day, approximately 2 million aged people experience the effects of injuries, two-thirds of which occur in the home.

Barriers to Health Maintenance and Illness Control

4. Identify some types of health services generally available to the aging.

"Potential" barriers become "real" to the extent that the old lack the skills or energy needed to overcome them and communities fail to provide necessary help. Barriers within old people, health practitioners, the health care system and society may keep the aged from obtaining health services.

Some aged people believe that symptoms of illness are normal and inevitable results of aging and therefore do not seek help. Others are aware of their need for help but lack the knowledge or energy required to reach available services. The poor and poorly educated lack skills needed to manipulate the system to their advantage.

Health professionals in general are oriented toward acute illness or the acute phase of chronic disease and have limited experience in management of long-term conditions. Some feel that they have little to learn from an old patient and that they cannot do much about his problems. Increasing demands for health care result in more pressure upon practitioners, who in turn give low priority to the needs of the aged.

The term "health care system" implies an unreality, namely, that most communities have an integrated network of health services and facilities and someone doing planning to meet health needs of the population. Most communities contain many services and facilities which offer potential aid to the aged person. Yet few have any mechanisms for assessing patient or family needs, determining how and where such needs can best be met, and helping people obtain the appropriate services.

The autonomy of providers of care is another barrier. Most agencies are independently administered, and the linkages between them are fragile or nonexistent. Because old people need a variety of services, they must knock on many doors to obtain help. Many health agencies define their mission in a rigid, narrow fashion and vigorously defend their territory against real or imagined encroachment by others. Fragmentation of information about the patient often occurs when he receives service from different agencies. Finally, the system creates particular hardship for old people in small towns, rural areas and the inner core of large cities. These are precisely the areas with the greatest shortages of health resources.

The major social factor affecting access to health services is the generally low social valuation of the aged compared with other age groups. When resources are scarce relative to demand, aged persons and other low-priority groups will be the last to receive them. Negative social valuation is reinforced by the fact that many old people are not only old but are also poor and ill educated and thereby possess low social status.

Types of Health Services

The delivery of care to the elderly in our health system is, as we stated, fragmented. Nevertheless, there exist four general types of services. (Write on the blackboard).

1. Ambulatory Care
2. Hospital Care
3. Other Institutional Care
4. Home Care

Let's move your chairs to form four separate buzz groups and I will assign each group a type of service. What I want you to do in the next 10 minutes is to develop a list of specific agencies or services available in this area in the general type assigned to your group.

(After about 10 minutes of buzz group, have the session reassemble as one group and pass out Info Sheet #4. Ask each group to share their list of specific resources with the large group. Strongly urge the participants to write the lists on Info Sheet #4 as you write them on the blackboard).

Factors Affecting Health Maintenance and Protection

5. Identify at least 5 elements in the environment which can directly affect health maintenance and protection of the elderly.

These seminars have shown us that getting older is universal but "growing older" is very personal. Aging itself is beyond one's control, but how a person ages is something he can influence substantially. For example, he can strengthen his chances for health through periodic medical examinations. He should be urged virgorously to have them.

Health and other professionals should help the individual understand his "normal"changes. They should help him "keep step" with his own music.

Most elderly persons don't resign. Even though modern society tends to reject him, the elderly individual generally strives to live fully despite difficulties of aging.

The individual person has a role to play in health protection and maintenance with respect to his own environment. There are a number of factors in his environment which can affect his ability to function normally as we have defined health.

For example, accidents represent one of the greatest threats to the aged who are well. Table I on Info Sheet 3 showed us that accidents are the sixth leading cause of death among the aging. For every fatal accident, there are probably 200 non-fatal but disabling accidents.

Therefore, knowledge of accident prevention in the golden ager's environment is an important factor affecting health.

(Write "accident prevention" on the blackboard). Let's make a list on the blackboard of other factors which can affect health of the aging.

(Spend about 10 to 15 minutes developing the list. Add any of the following items which the participants overlook. Then ask, "why are each of these items important to health?" Spend another 10-15 minutes answering this question for each item. See Volume I, Working With Older People: The Practitioner and the Elderly, pp. 32-41, for background discussion.

1. Accident prevention
2. Climate - not a decisive factor
3. Clothing
4. Mobility
   a. Walking
   b. Driving
   c. Public transportation
5. Drugs and Medicine
6. Family
7. Food, Nutrition, and Eating
8. Health insurance

9. Housing

10. Finances or income

11. Leisure and the use of time

12. Mental hygiene

13. Care of feet

14. Care of teeth

15. Physical activity and experience

16. Sexual needs

17. Work)

Principles of Management

6. Discuss 5 basic principles of health management.

Up to this point in our discussions during this seminar, we have dealt with physical, psychological, sociological aspects of aging, defined health and looked at its meaning in terms of services available, or, perhaps, not available, and the factors which can affect health protection or maintenance. In summary, we have seen that medical care alone does not solve aging problems or prevent them. The problems of aging are multiple rather than single, and because of that multiplicity we can now survey some basic principles of management for all practitioners dealing with the elderly.

(Pass out the Info Sheet 5. Read the opening paragraph. To stimulate discussion, ask a participant to read one of the five principles, asking him what it means to him in his own words, and how he can apply that principle in his work situation with the aging. Allow about 2 or 3 minutes for discussion of each principle).

I think that it is quite clear to each of us that these principles are key factors in our work situations. The film we are about to see will help us to sharpen our ability to use these principles.

The title of the film is "Seasons" and deals with the health and rehabilitation of older people from the view of what it means to be old in America (sick and outcast), and what we should do to prevent wasted lives.

As you watch the film, I would like you to take notes for later discussion. In particular, please look at each geriatric program shown, and make a determination of which programs, in your opinion, fulfill the five principles of management effectively.

(Show the film "Seasons", 16 minutes, and stimulate discussion afterward by asking:

1. Which program or programs depicted best fulfill the five principles?

2. Was there any program shown which fell short of the principles?

3. How did it fall short?

Allow about 10-15 minutes for discussion).

This concludes the material for today's session. Session Four will meet on _____(day) at _____(time) at _____(location). Thank you for coming today, and I will see you then.

TABLE I

CAUSES OF DEATH FOR PERSONS 65 AND OVER, U.S.		
Cause	Rate per 100,000 population	% of Total
Diseases of the Heart. . .	2,823.9	51.3
Cancer	901.4	16.4
Stroke	901.0	16.4
Influenze and pneumonia. .	213.7	3.9
General arteriosclerosis .	198.9	3.6
All accidents.	155.0	2.8
Diabetes	122.9	2.2
Other diseases of the circulatory system	97.4	1.8
Other bronchopneumonia diseases	47.3	0.8
Other hypertensive diseases	47.3	0.8
Total	5,508.8	100.0

SOURCE: National Center for Health Statistics

TABLE II

PERCENT OF NONINSTITUTIONALIZED PERSONS 65 and OVER LIMITED IN ACTIVITY DUE TO CHRONIC CONDITIONS, U. S.	
Condition	Percent of old people who are limited as a result of that condition
Heart Conditions	22%
Arthritis and rheumatism	21%
Orthopedic impairments (excluding paralysis or absence of arms, legs, back, spine or hips).	11%
Visual impairments	9%
High blood pressure	8%
Mental and nervous condition	6%
Genitourinary conditions; paralysis. .	4% each
Diabetes; asthma and hay fever; hernia; hearing impairments.	3% each
Varicose veins; chronic sinusitis and bronchitis	2% each
Neoplasms (cancers); peptic ulcer. . .	1% each
Hemorrhoids; tuberculosis	less than 1% each

SOURCE: National Center for Health Statistics

TYPES OF HEALTH SERVICES

1. Ambulatory Care
   - A. Doctor's offices
   - B. Clinics
     - a. Public
     - b. Private
   - C. Hospital outpatient departments
   - D. Group Health settings
   - E.

II. Hospital Care
   - A. General hospitals
   - B. Special hospitals
   - C.

III. Other Institutions
   - A. Psychiatric facilities
     - a. Public
     - b. Private
     - c. Psychiatric units in general hospitals
   - B. Nursing home type facilities
     - a. Extended care nursing homes
     - b. Nursing homes
     - c. Traditional homes for the aged
     - d. Adult foster homes
     - e. Boarding homes for the aged
   - C.

IV. Home Care
   - A. Home nursing care
   - B. Homemaker - home health aide
   - C. Nutrition programs
   - D.

PRINCIPLES OF MANAGEMENT

The challenge of health protection and maintenance for the aging is more than medical. In other words, medical treatment is necessary but not enough. Physical, psychological, and social factors must be considered in caring for the elderly. The problems of aging are multiple rather than single. In short:

1. Treat the person, not the sympton.
2. Treat the person with purpose and hope.
3. Tailor the treatment to the individual's strengths and weaknesses; don't expect too much, but don't expect too little.
4. Rely on an integrated team approach to health using the full range of community resources.
5. Remember that successful treatment of a disease is a tactical achievement, no matter how great. The successful maintenance of health or role function is the basic strategy.

SESSION FOUR

HOUSING AND ITS RELATIONSHIP TO HEALTH

PURPOSE: To develop in each participant an awareness of housing problems facing the aging individual, how these problems affect health maintenance, and some criteria for the solution of those problems.

OBJECTIVES: At the completion of this session, the participant will be able to:

1. Identify typical housing problems of the aging and their relationship to health. (30 minutes)
2. Discuss the nine general types of housing arrangements for the aging. (15 minutes)
3. Discuss the four major categories of associated services which affect housing arrangements. (10 minutes)
4. Suggest alternative solutions to the problems of housing that meet the needs of our aging population. (45 minutes)

TIME: About 2 hours.

MATERIALS NEEDED:

A. Information Sheet #6 - "Case Studies in Housing"
Information Sheet #7 - "Types of Housing Arrangements"
Information Sheet #8 - "Associated Services Which Affect Housing Arrangements"

B. 16 mm film, "Step Aside/Step Down", 20 min., color.

C. 16 mm film projector and screen.

D. Blackboard or flip charts with felt pens.

SESSION FOUR
HOUSING AND ITS
RELATIONSHIP TO HEALTH

OBJECTIVES

PROCEDURES

Welcome to the fourth in the series of seminars entitled "Maintaining Good Health in Late Life". You will recall that during our last session we listed on the blackboard (flip charts) a number of environmental factors which can have a direct bearing upon health, or as we defined it, the ability to carry out normal role functions. In this and the next few sessions, we will be discussing four major environmental factors in much greater detail. Those factors are:
(Write on the blackboard)

1. Housing
2. Environmental Safety
3. Food, Nutrition, and Eating
4. Time and Leisure

We will undoubtedly learn much more about how each of these factors play a part in both physical and psychological health maintenance.

The learning objectives for this particular seminar about housing for the elderly are to enhance:

1. Your ability to identify typical housing problems and their relationship to health maintenance.
2. Your ability to discuss the nine general types of housing arrangements for the aging.
3. Your ability to discuss the four major categories of associated services which affect housing arrangements.

Your ability to suggest alternative solutions to the problems of housing that meets the needs of our aging population.

Problem Identification

1. Identify typical housing problems of the aging and their relationship to health.

Housing in the United States is a symbol of security and status. Two-thirds of the 65 and over population live in their own homes. They prefer this kind of independent living. But where do, or should, they draw the line between independence and safety or the maintenance of health?

In order to get some idea of the problems involved, let's look at some actual cases which seem to be typical of those here in North Carolina.

While I am distributing Information Sheet 6, please move your chairs to form 5 separate buzz groups. I will assign one case to each group. Then, I want each group to identify the housing problems in the case that affect the health of the person involved.

Remember, identify the problems, but do not attempt to solve them.

(Hand out Information Sheet 6 and assign cases. Allow about 10 minutes before reforming the class).

(Now proceed through each case, having one member of the buzz group read the case aloud. Then ask the group spokesman to identify the problems and how each relates to health. Be alert for problem identification; solutions are <u>not</u> desired at this point. This should take about 15 minutes).

Please save your notes and Information Sheet 6 for use later during this session. We will return to these cases later.

<u>Housing Arrangements</u>

2. Discuss the nine general types of housing arrangements for the aging.

There are about nine different types of housing arrangements, one of which will probably fulfill the needs of an individual as they relate to shelter and health protection.

(Hand out Information Sheet 7 and suggest that it be used for notes. The participants will be using Information Sheets 6, 7 and 8 later during this session.

The possible array of arrangements includes:

1. <u>Independent housing in the community</u> either in multiple-dwelling buildings or individual residences. Such housing has no special design for the elderly, is not segregated, but is simply part of the supply of the community's housing. It is in good repair, healthful, and desirable for human habitation.

2. Independent housing with special architectural elements geared to the special physical, psychological, and social needs of the elderly. Such specialized housing may be composed of independent houses or multiple-dwelling units which have the capacity of furnishing a unit which makes independent living, including the preparation of meals, a possibility.

3. Specially designed housing for the elderly in multiple-dwelling units with small Pullman-type kitchens which are intended only for breakfast and snack-time use but which can be used for preparing a meal if necessary. Such housing has common dining rooms, activity rooms, and lounge areas and may have special purpose areas for office space, medical dispensary or clinic rooms, counseling areas, and so forth.

4. Specially designed group-residence care facilities. Group-residence care is a first cousin to a retirement hotel. Accommodations which might be provided in group-residence care facilities are sleeping rooms without any kitchen facilities, common dining and kitchen facilities, "coffee kitchens" with associated small unit lounges for groups of apartments, central lounge areas, central dispensaries to provide for dispensing of medications, or provision of a sick-call type of medical attention, and a central switchboard manned on a 24-hour basis, combined with a front desk similarly manned.

5. The retirement hotel is similar in physical nature, although typically it would provide something less in the way of services, particularly in the medical area.

6. The home for the aged, while somewhat declassé, has not faded entirely from the scene, and there are still groups which are interested in establishing such homes. These homes are looking more and more like group-residence care facilities, although they may have associated sick-bay arrangements or small infirmaries, and make arrangements for the care of the individual in his room in the event of temporary disability.

7. Some homes for the aged are providing for retirement cottages on their grounds. This is the bridge between independent living and the supports which an institutional setting can

provide. The retirement cottage permits a couple, usually, to prepare individual meals and participate in the activities of the home, enjoying both the independence of living in a separate unit and the security of knowing there is a place that will care for them in event of sickness.

8. A development of the past decade is the retirement village. This is the community of retired persons. It takes various forms, sometimes elaborate and planned like Cape Coral, Florida, and in other instances less planned but no less a retirement village, as in the scores of trailer camps in Florida occupied almost entirely by elderly, retired persons. Some retirement villages are geared to catering strictly to the well. Others have elaborate arrangements for medical care, provided through so called nonprofit corporations like the Golden Rain Foundation.

9. Another little-used arrangement but one with a very high potential is the genuine cooperative congregate-living facility. In this kind of arrangement a small group, perhaps 10 or 15 persons living together, eating in a common dining facility, doing the work required in the house themselves, utilizing an indigenous manager, pooling their resources in order to purchase the food, hire a cook, buy paint, and so on. Admissions and discharges are handled by the group itself. The facility operates under the wing of some kind of parent agency -- in one case a public housing authority, in another a local parish. However, the level of intervention is extremely low. In fact, after a time, it may be nothing more than a voice at the end of a phone, available when needed.

Certainly from this smogasbord of housing arrangements there exists some type that best fulfills the individual's needs. For purposes of this discussion, however, we must focus on the most appropriate arrangement for any given person with a set of given problems.

Associated Services Which Affect Housing Arrangements

3. Discuss the four major categories of associated services that affect housing arrangements.

Services can be grouped in four major categories, all of them supportive and designed to assist the individual to adjust to his environment and give him support when he needs it so that he can operate

at the outermost limits of his physical, psychological and social capacities.

(Hand out Information Sheet 8 and again urge that participants take notes for further use in this session).

These categories and the services under them are as follows:

1. Medically oriented services:

   a. Medical sick-bay and health clinic services located within or adjacent to the housing facility.

   b. Organized home medical care -- usually hospital-based, although not always, and available to help a family maintain a person in the home while at the same time providing a high level of physician service with associated nursing care, occupational and physical therapy, and often social services.

   c. Visiting-nurse service.

2. Services designed to enhance the individual's ability to participate in the activities of daily living -- dressing, bathing, meal preparation, housekeeping, shopping, coming and going, and the like. These services include:

   a. Homemaker-housekeeping services.

   b. Food services, whether through congregate feeding arrangements, meals-on-wheels, or arrangements with commercial restaurants.

3. Services designed to increase or maintain appropriate and healthy levels of social contacts and raise the level of the sense of life fulfillment. These services include:

   a. The entire range of day-center and group-work services which include for the elderly, educational programs, recreational programs, sheltered workshop opportunities, volunteer service opportunities, provision for games, and the like.

   b. Friendly visiting services.

c. Provision of facilities and equipment for recreation and arrangements for entertainment, field trips, and so forth.

4. Problem-solving and social supportive services. These would include:

a. Social service counseling programs.

b. Legal counseling programs, including an array of protective services.

c. The benign surveillance type of service, which is an unobtrusive oversight of vulnerable people, often by a desk clerk, a dining room supervisor, or other personnel, to assure that someone isn't doing something dangerous to himself, going out ill-protected in inclement weather, and so on.

Consider the services, the type of housing, and the possibility that, for any given housing arrangement, we might apply services singly or in combination, we have literally hundreds of possibilities from which to choose in order to select the most appropriate facility for any given individual.

Now, before anyone accuses me of reducing man and his desires to a set of combinations of housing arrangements and services that match with mechanistic precision, let me hasten to say that it is much easier said than done.

And, finally, we must be quick to avoid confusion about what a person needs when his major problem may be lack of money. As toilers in the vineyard of public welfare, we have sometimes overstated that thesis. However, we know how abrasive harsh poverty can be. We know that one-third of the elderly live below the poverty line, and they live there at a time of life when physical beauty has fled, work is no longer available, and friends and family are gone.

To be sure, very few communities in North Carolina enjoy the luxury of the full array of housing arrangements and services. However, unless we begin to recognize how often we settle for something less than the housing arrangement of choice, we will not be able to advise our clients with respect to meeting their needs.

Alternative Solutions

4. Suggest alternative solutions to the problems of housing that meet the needs of our aging population.

To make the foregoing arrangements and their service more vivid, I am going to run a 20 minute film titled "Step Aside/Step Down". This film looks at what the "Golden Years" have in store for you if you don't have enough "gold"--poverty, welfare, food stamps. It will show some excellent West Coast alternatives in living arrangements, and highlights two miniority alternatives. Among other things, it advocates senior power, jobs, and retraining programs.

However, what I would like for you to do now and during the film is re-read the case study assigned to your buzz group earlier in this session. When the movie is completed, reform your original five groups. Each group is to then select the best alternative housing solution for their client, taking into account Information Sheets 6, 7, and 8, and the movie alternatives. We will spend about 10 minutes after the movie in groups and then share with the other participants the alternative each buzz group selected for their case and the reasons for that choice.

(Begin the film "Step Aside/Step Down").

(Break into the five original buzz groups).

(Discuss the recommended solutions with the class).

That completes the material for this fourth session. The fifth session will involve environmental safety and health protection. I will see you all again on _____(day) at _____(time) at _____(location).

Thank you for attending.

CASE STUDIES IN HOUSING

CASE 1: Mr. H., an unemployed farmer, is unable to work at other than a small gardening job, due to an injury. He lives on the second floor of a structure built decades ago to support a water tank. Light from the two tiny windows reveals that bare, barn-like walls which keep out neither wind nor rain, and the dingy, make-shift furniture. Heating, electricity, and plumbing are non-existent. The lower story is crammed with litter, and from this, one climbs a rickety ladder to reach his own room.

CASE 2: Mr. K. lives in a single room on the ground floor, as he cannot climb the stairs to the second floor bedroom. Heat is provided by the cooking stove on which he keeps a large pail of hot water, which helps to distribute some heat. The floor is broken, unsafe and ingrained with grease and dirt. The room is poorly lighted and Mr. K's. eyesight is dim.

CASE 3: Here is an elderly gentleman 80 years old living alone in his rundown farm house, with absolutely no conveniences, not even a refrigerator. He is confused, depressed and upset. He says that it costs him $50 a month to maintain the house. He says that he has poor vision, poor hearing, crippled hands and legs, shortness of breath, and his feet and legs swell, and he's forgetful. He said that the food cost is $20 a month. And the old gentleman says that he just doesn't know what to do. He tells me that a neighbor lady comes in and cleans, but the house is dirty, and he too is dirty.

CASE 4: Mr. G., 82 years old, lives with his wife in a 3-room house they own in Wayne County. The house has no electricity or indoor plumbing. They do have a cooking stove, but no refrigerator. The house and furnishings are filthy and badly in need of repair.

CASE 5: Mrs. P. lives in an old summer house which was once part of a large estate. The garden is so overgrown that there is only a small path to the front door and another to the back door. Some of the windows are boarded up, and one of the three rooms is not usuable because the roof leaks. Mrs. P. has no tub or shower. A tiny gas heater provides a feeble warmth, at considerable risk of burning the whole place down.

TYPES OF HOUSING ARRANGEMENTS

1. Independent housing.

2. Independent housing with special architecture.

3. Specially designed, multiple-dwelling units.

4. Special designed group-residence care facilities.

5. Retirement hotel.

6. Home for the aged.

7. Retirement cottages.

8. Retirement village.

9. Cooperative congregate-living facility.

ASSOCIATED SERVICES WHICH AFFECT HOUSING ARRANGEMENTS

1. Medically oriented services:
    a. Clinics
    b. Home care
    c. Visiting nurse

2. Individual ability enhancement:
    a. Homemaker-housekeeping
    b. Food services

3. Social contact:
    a. Group work
    b. Friendly visiting
    c. Recreation and entertainment

4. Problem-solving and support:
    a. Social service counseling
    b. Legal counseling
    c. Surveillance service

ENVIRONMENTAL SAFETY

PURPOSE: To develop within each participant an understanding of the relationship between environmental safety and health maintenance of the aging.

OBJECTIVES: At the end of this session the participant will be able to:

1. Discuss physical and emotional factors that relate to severity or cause of accidents. (20 minutes)
2. Develop a list of accident prevention measures for the environments in which the aging person functions. (25 minutes)
3. Identify psychological hazards to safety and life, and discuss alternative solutions. (60 minutes)

TIME: About 1 3/4 hours.

MATERIALS NEEDED:

A. Blackboard or flip charts and felt pens.

B. 16 mm film projector and screen.

C. Movie "Now is Forever", 41 minutes, color.

D. Information Sheet #9, "Environmental Hazards and Safety".

OBJECTIVE

PROCEDURES

Once again, welcome to this set of seminars titled "Maintaining Good Health in Late Life." The series has dealt with the three processes of aging, biological, psychological, and social, in order to develop our awareness and sensitivity to the true or normal situation of growing older. Each, as we have seen, has both a direct and indirect impact on the health problems which may develop for the aged person. During this session, we plan to focus on health from the standpoint of environmental safety. Health as we have defined it has two separate but similar meanings. The first was derived from the W.H.O. constitution; the second in terms of ability or function.

(Ask the participant for the definitions)

(ANSWER: A. a state of complete physical, mental or social well-being.

B. the ability to function in order to carry out normal roles in the community.)

In light of these definitions, let's look at both the physical and mental environment of the elderly, the health problems they can create, and some solutions to the problems.

The plan for this seminar will be a brief lecturette on the aging process to give us a starting point, a discussion of the hazards in the environment, and some solutions. I urge each of you to take notes for use later in the session.

Physical Aging

1. Discuss physical and emotional factors that relate to severity or cause of accidents.

You will no doubt recall from the last session that accidents were as important a cause of death as pneumonia and diabetes. Ten percent of the over 65 population sustains some 70 percent of all fatal falls, 30 percent of all pedestrian accidents, and 29 percent of all deaths due to burns and fires. In addition to 25,000 accidental deaths, some 3 million persons over 65 are injured, 1 million of which are hospitalized or bed disabled.

OBJECTIVE

PROCEDURES

After age 19, there is a gradual slowing down of the rate of division, growth, and repair of body cells, with function at a lower recuperative ability after injury or disease.

Another phenomenon occurs in the aging body. Homeostasis is the process whereby the body maintains basic physiological function within normal limits, such as temperature, cardiac output and respiratory rate, and acts to restore normal values under stress of blood loss, fever, and injury. With age, homeostasis becomes less efficient, and stress will cause departure from normal physiological limits and a prolonged recovery time.

Changes occur in other bodily functions also. We see them in the central nervous system, degenerative changes, gait, social degeneration, balancing mechanism, vision, hearing, other sensory perception, muscular involvement, skeletal system, and medication effects. Each can heighten the danger level to the older person. Let's look at each item.

Central Nervous System. Several thousand brain cells die each day during the latter half of life. By age 75, the brain is 56 percent of its original weight. Number memory begins to decline at 27 years, design memory at 32, inductive reasoning at 23. Reaction time is prolonged, learning capacity decreased, and memory impaired. Prolongation of reaction time is an obvious cause of accidents in industry among drivers, pedestrians, and in the home.

A degenerative change such as chronic brain syndrome, together with chronic illness and malnutrition, results in decreased alertness and self esteem and a sense of detachment which cause falls, burns, and pedestrians accidents.

With aging, gait becomes uncertain and the feet tend to shuffle. As a result, extension cords, rug edges, minor irregularities in floors or sidewalls become major hazards.

OBJECTIVE

PROCEDURES

One type of aged person prone to accident is the accumulator who saves everything. He is subject to falls over his treasure, fires among them, or may die cornered by them. The balancing mechanism of the body is affected by changes in the brain, loss of position, sense and tactible sensation in the limbs, and decrease of muscle strength. As a result older people lose the ability to pull back out of an incipient fall.

Failing eyesight often is the first overt sign of aging. Bifocals can cause uncertainity as to the location of feet on a staircase. There is an increased need for illumination, a decreased ability to distinguish light intensity, a decreased tolerance of glare, a decrease in night vision, and a narrowing of the visual field. The older person's safety is jeopardized when driving a car, walking as a pedestrian, or in the home.

With aging, there is progressive hearing loss due to inner ear and nerve degeneration. The sound of a car or other danger warning signals may be unheard. The world becomes dead, as background noises, which keep us in contact with life, are lost. Depression, withdrawal, and paranoia result with lessened self-care, apathy, and accidents.

Other sensory perceptions age. Decreased perception of heat, cold, and pain together with slowed reaction time result in severe burns from water bottles, wet dressings, heat pads or bath tubs.

The loss of muscular strength, speed, and coordination is not confined to skeletal muscle but involves the gastroentestinal tract as well. The act of swallowing initiates a finely coordinated reaction by nerve and muscle which transmits food from pharynx to stomach. In younger age groups, each swallow is almost always followed by a successful peristaltic wave. In the aged, delayed and abnormal peristalsis occurs about half the time. A grave danger of aspiration of food into the lungs results which will cause potentially fatal pneumonia, particularly in bedridden patients fed in a semi-reclining position.

OBJECTIVE

PROCEDURES

High disease and death from bone fractures in the aged is intimately related to the continual bone formation which is lessened in the aged. The process begins centrally in the long bones and skull. It is estimated that as many as 25 percent of the aged develop fractures of the spine, often without any injury or with such minor stresses as sneezing or opening a window.

Since medications are not efficiently detoxified in the liver and excreted by the kidney in the aged, an accident hazard is produced. Irregular, rapid heart rates occur which make walking and driving hazardous. Certainly the aged are prone to errors in dosage, timing, and omission of drugs or taking the wrong one. Transquilizers may cause dangerous falls in blood pressure on standing up.

Psychological factors complicate the physical dangers. Emotional strain, boredom, loneliness, preoccupation, anxiety, authority, frustration, vulnerability cause to accidents.

Prevention of Accidents

2. Develop a list of accident prevention measures for the environments in which the aging person functions.

With this brief review in mind, we will now break into three groups, each of which will be given an environmental location. I would like each group to develop a list of possible hazards, or design elements which can cause accidents in that location. The three environmental locations are the home, a shopping trip, and the place of work.

For example, the list for the home would include hazards or safety design features in the kitchen, like electric, not gas, stove in the kitchen, grab rails on the tub in the bathroom, and nonskid treads on the stairs.

The "shopping trip" group would think about driving walking, and the hazards one may encounter at a store.

The "place-of-work" group might develop their list from the kinds of functions that workers perform on the job like climbing, lifting, machine operations, and so forth. What are the hazards, and how would you advise a person to skirt them.

OBJECTIVE

PROCEDURES

(Break the participants into three groups, assign each a topic, and allow 15 minutes for their discussion.) (After about 15 minutes of buzz group work, reform the large group and have each share their developed list with all participants. Ask all the participants if they have any additions to each list. Allow about 10 minutes for each group to present.)

(Pass out Information Sheet #9)

These lists are meant to be suggestive of environmental hazards and caution, not exhaustive. You have no doubt added other items during your group work. The purpose of this exercise has been to sensitize all of us to physical hazards in the life space of the older person.

Emotional Hazards

3. Identify psychological hazards to safety and life, discuss alternative solutions

As we discussed in this session, emotional strain and stress can intensify the physical dangers to the older person. Depression, anxiety, fear, or withdrawal from life are not, repeat not, necessarily concomitant with growing older. In fact, emotion stress is an environmental hazard in and of itself. Just as one can physically function in his role with a handicap from chronic diesase such as arthritis, an older person can overcome psychological health barriers to living life with gusto.

I am now going to show you an excellent film titled "Now is Forever" which focuses on some people who just happen to be very old chronologically, but who have chosen positive alternatives to the hazard of a stagnant life.

As you view the film, please look for answers to the following questions:

(Write questions on the blackboard.)

1. How have the following people overcome the physical and emotional hazards of their environment?

OBJECTIVE

PROCEDURES

a. The jogger
b. The artist's model
c. The craftsman
d. The photographer
e. The actress
f. The publisher

2. What is the message in this film?
(Answer: Live life now because now is forever; an affirmation of life to its very end.)

(Show film, "Now is Forever", color, 41 minutes)

(Upon completion, start a 15 minute discussion of the film by asking . . . .)

Which person, in your opinion, overcame best the environmental hazards facing him/her? How did he or she make the hurdle?

(Ask questions #1 and #2 above.)

I would like to add one more thought before we conclude. The final and inescapable responsibility for a healthy life, physically and emotionally, rests with the individual. No one can live it for him. The challenge for us who counsel the aged, however, is to light that spark by offering alternatives to the person. As the Buddhist proverb says, if I give you a fish today, you will still be hungry tomorrow. If I teach you how to fish, you will never be hungry.

Session Six will meet on _____ at _____ at _____ _____. Thank you for attending this fifth session.

ENVIRONMENTAL HAZARDS AND SAFETY

In the home

Design features:

- Adequate sunlight, heat and ventilation
- Rooms on one level, floors with non-slip materials
- Bath-tubs and showers with grab bars or safety rails and non-slip bottoms
- Cabinets and closets accessible without use of stools or frequent bending
- Electric stoves if possible; if not, oil and gas stove vented to the outside
- Labor-saving devices as economically feasible
- Telephones and buzzers in apartment to summon help in emergency, and someone to "look in" periodically
- Minimal use of stairs

Other precautions:

- Light well stair landings and cellar steps
- Improve handrails for both sides; size for full effective grasp; extend at top and bottom
- Paint top and bottom steps brightly; use nonskid treads, and/or paint risers in easily seen colors
- Put windows in doors in stairwells
- Do not use small mats, sliding rugs, slippery linoleum
- Wear stable, non-sliding shoes
- Tack down ends of rugs
- Remove thresholds
- Baseboards lights, and adequate light at bedside table and from bed to bathroom
- Easily accessible light switches
- Flashlights handy for emergencies
- Remove extension cords, rickety tables, chairs on casters, and sharp cornered furniture

- No smoking in bed
- Mark stove dials distinctly for "feel"
- Set water heater temperature very low, about 110 degrees
- Put a seat in the bath tub
- Wear non-flammable clothes, particularly night clothes
- Place spring-safety caps on gas jets
- Periodically houseclean all medicine cabinets
- Label drugs with large letters and with special notation of internal or external use.
- Good lighting at medicine cabinet with magnifying glass available.
- Plan alternate fire escape routes from every room
- Use low beds so feet rest comfortably on floor
- Raise toilet seat for ease of use without dangerous sit downs.

On a shopping trip

Poor night vision, non-tolerance of glare, diminished field of vision, and lessened visual acuity coupled with slower reflexes are major problems

Driving

- Do not drive at night, during peak traffic periods, or in bad weather
- Use small car
- Wear visual and hearing devices as prescribed
- Learn meaning of new traffic signs and laws
- Do not use difficult or high speed routes
- Do not drive while under medication

Walking

- Do not cross between intersections, behind parked cars, or walk in the roadway
- Use a walking device (ie, cane)
- Do not carry any large or many packages

- Use a wheeled market cart
- Wear distinguishing clothing at night
- Time traffic lights once before crossing
- Ask for help at intersections

The store

- Use great caution on escalators
- Shop in well lighted stores
- Do your shopping during daylight hours
- Pace yourself to avoid tiring
- Use regular doors, not revolving
- Wear proper shoes and comfortable clothes

At the place of work

Employee's safety:

- Wear protective devices such as ear plugs, hard hats, safety glasses gloves, etc.
- Always wear vision and hearing aids
- Wear proper non-skid shoes and well fitting clothes
- Adjust speed of work to capability
- Do not handle heavy goods beyond physical capacity
- Avoid climbing stairs if possible
- Use good lighting
- Females should never lift weights in excess of 25 pounds
- Practice proper lifting habits - lift with legs, not with the back
- Use a cart or dolly to move heavy loads, and ask for help
- Never wear jewelry or clothing that can get caught in equipment
- Don't tease or get involved in horseplay
- Use a sturdy ladder, not a box or chair to stand on
- Label supplies distinctly

- Know how to operate fire extinguishers
- Use swinging doors with caution. Label "in" and "out" doors

Environmental hazards and safety:

- Keep floor and stairs in good repair
- Keep floors clean and dry to avoid slipping - wipe up spilled foods or liquids immediately
- Place floor mats in areas where needed to prevent slipping
- Keep traffic lanes, exits, and entrances clear.
- Barricade and do not use areas that are being cleaned.
- Close cupboard and storage area doors when not in use.
- Keep storage areas adequately lighted
- Keep halls and passageways well lighted
- Place guard on all light bulbs
- Identify danger areas, fuse boxes, and electrical outlets by marking with bright colors
- Mark overhanging objects to prevent collisions
- Locate electric cords so they do not create a hazard for personnel
- Locate electric outlets where water cannot be splashed or spilled on them.
- Keep rest rooms and locker rooms clean and uncluttered.
- Maintain good housekeeping in all areas to reduce the hazard of fire
- Post the fire department number in several conspicuous places

The first requirements which should be met to provide an efficient safe environment in which to work are good lighting and adequate ventilation.

When work areas are poorly lighted, the work capacity of workers is reduced and the probability of accidents occuring increases.

High temperatures and humidity lessen the alertness and muscular activity of workers.

GERIATRIC NUTRITION

PURPOSE: To help the participant develop an understanding and knowledge about nutrition as it relates to health maintenance

OBJECTIVES: At the completion of this session, the participant will be able to:

1. Discuss the difference between food, nutrition, and eating, and the obstacles to developing adequate habits in each.
2. Discuss the importance of dental health for the aging.
3. Identify resources in the community to solve specific nutritional health problems and life situations of the elderly.
4. Develop a proper two-day menu for an elderly client after identifying need and matching resources to meet the need.

TIME: About 1 3/4 hours

MATERIALS NEEDED:

A. Blackboard or flip charts with felt pens

B. Information Sheet #10: "Resources to Meet Nutritional Needs"

Information Sheet #11: "Case Studies and Instructions for Their Use"

Information Sheet #12: "Nutrition Suggestions that May Make You Feel Better"

Information Sheet #13: "Helping People to Eat and Enjoy"

Information Sheet #14" "Daily Food Guide"

OBJECTIVE

1. Discuss the difference between food, nutrition, and eating, and the obstacles to developing adequate habits in each.

PROCEDURES

Good morning/afternoon. Welcome back to Session Six in the seminar series, "Maintaining Good Health in Late Life." One of man's most basic needs for survival is food; the elderly American is no exception to this concept. Today, we are going to discuss geriatric nutrition and its relationship to our definitions of health and health maintenance. We will distinguish among food, nutrition, and eating, discuss obstacles to each, and identify some communtity resources.

Before proceeding, however, are there any questions from previous sessions you would like to discuss?

(Allow 5-10 minutes for questions.)

By way of introduction to the subject of nutritional health, some knowledge of needs has become recently available. Findings in national studies to determine community needs based on 18 categories of potential health problems, revealed that the need to modify food habits outranked all other categories. The need for help with modified diets ranked third. Other reports have emphasized that in order to maintain good health and independence the aged person required definitive health counseling including nutritional guidance.

This subject of food and eating, then, is vitally important to us in our work with the aging, and to the aging person in motivating him or her toward better health goals. Moreover, we should be aware that the older person's food choices and practices represent a lifetime record, perhaps three quarters of a century, which has been influenced by multiple environmental, emotional, and physiological factors.

Food, Nutrition, and Eating

Food is the object, nutrition is the biological process, eating is the social behavior. (Instructor may wish to repeat this sentence for stress). Each has a particular and vital role to play in the well being of the aging person.

OBJECTIVE

PROCEDURES

It will hearten the aging person to know that if his food habits are basically sound, little change is necessary in later years. It may be necessary to change shopping habits to adjust to a smaller family, or learn how to prepare appetizing menus for only two persons, or only one. But the kinds of foods one eats need not change with age.

Nor is it necessary to have vitamin pills, if a balanced diet is maintained. Thus, vitamin purchases generally are an unnecessary burden on the incomes of the elderly.

Digestive processes slow down, and older persons should be encouraged to adjust meals sizes and frequency. They may find small, frequent meals better than the customary two or three large meals a day.

Where necessary, older person should be advised to reduce caloric intake to a level consistent with the degree of activity. A suggested optimal weight is the same as one's weight at age 25; there should not be any marked increase. The criterion for caloric adequacy should be an intake which maintains optimal weight. Fasting or drastic diet is not desirable. Obesity is often a mask for protein deficiency, though.

Malnutrition may be responsible for many of the aged's complaints of general weakness, irritability and other psychological symptoms. The deficiencies are a consequence of reduced income and the resultant increased proportion of carbohydrates--usually cheaper than meats---in the diet. They may also result from poor cooking and eating habits. Diet advice to the elderly might include these hints:

--An adequate supply of fruit, vegetables and milk will provide most vitamins and minerals.

--Some of the more easily digested foods are those that are boiled or baked, or low in fat content, do not demand a great deal of chewing, and are well cooked.

OBJECTIVE

PROCEDURES

--Some of the more difficult foods to digest are those that are fried, are highly seasoned, contain large amounts of fat, gravies and heavy sauces, and certain raw fruits and vegetables and foods heavy in carbohydrates.

--The role of fats in maintaining health is still a subject of controversy. Research is not yet sufficiently conclusive to recommend drastic changes in the kinds of fat (saturated and unsaturated) that should be consumed. However, it would be prudent for persons with atherosclerotic heart disease or a coronary occlusion to eat less fat and to substitute unsaturated for some of the saturated fat.

--Generally speaking, the diet should be low fat, medium carbohydrate, high protein.

--A sudden and persistent loss of appetite should get medical attention. Poor appetite is often related to the poor condition of the teeth or ill-fitting dentures, and they should be checked.

Other suggestions for eating and diet might include:

--To prevent constipation, include fruits and vegetables and foods with bulk. Older persons should be discouraged from the habitual use of laxatives.

--In hot, humid weather, daily fluid intake should be increased to 6 or 8 glasses, and salt intake increased, unless contraindicated medically.

--Heavy meals should be avoided at all times, but particularly before going to bed.

Eating is very important to older persons. It should be enjoyed. The older individual who lives alone should be encouraged to invite a friend or relative to dinner as often as is feasible, so that eating becomes a social occasion. Anything else that adds to the pleasure of eating should be encouraged--for example, the use in moderation of spices, coffee or tea, wine or other alcholic beverages.

OBJECTIVE

PROCEDURES

Eating and food intake are very closely entwined with emotions and moods. Thus, when a person is tense, he may overeat. Or the angry or hurt elderly person may eat very little, expressing his protest through a sort of self-imposed starvation. Emotional good health is important to good eating and adequate sustenance; good eating and adequate sustenance are important to emotional good health.

Obstacles to Adequacy

The foregoing remarks touched on a number of physical, emotional and social obstacles which hinder the proper habits of nutrition and eating. Let's recap them in five catefories.

(Write on the blackboard. . .)

1. Income
2. Appetite
3. Incentive
4. Emotion
5. Dentition

(Ask the participants how each factor can be an obstacle to adequate nutrition.)

ANSWERS:

1. Income: Limited income may restrict the purchase of adequate amounts or right kinds of food, and provide for no more than meager, cooking facilities and refrigeration.

2. Appetite: With aging, appetite is usually decreased which affects the desire to expend effort to cook or raise a fork.

3. Incentive: Reduced activity, increased fatigue and weakness, or living alone may affect the incentive for eating.

4. Emotion: Loneliness, unhappiness and

OBJECTIVE

PROCEDURES

anxiety can lessen the appetite and lead to disinterest in food. Fewer active taste buds, diminished acuity of sight and smell, and lessened motor skills also may bring about a deficient intake of food.

5. Dentition: Inadequate, either none or ill-fitting plates, can create vast difficulty in eating, difficulty that is almost insurmountable.)

Dental Health

2. Discuss the importance of dental health for the aging.

The fifth factor, dentition and dental health, are often overlooked by all Americans, but in particular the elderly. This factor is extremely important to health maintenance. Let's spend a couple of minutes to touch upon the subject of dental health. Several health surveys state that dental disease is "the most prevalent of all illnesses in the United States." It increased with age and it has a serious effect on total health. Untreated dental disease plays some part in the poor diet and malnutrition from which a high percentage of older persons suffer. Dental services needed by the elderly are:

1. Need for extraction of diseased teeth.
2. Need to be fitted for dentures, partial, or complete.
3. Repair of broken or ill fitting dentures.
4. Treatment for gum and bone diseases.
5. Examination for possible cancer of tongue, lips, cheeks, or throat.

There appear to be three main barriers for the elderly in obtaining dental services:

1. Cost - the chronically ill and aged have used up most of their resources.
2. Accessibility - the great majority of each group need help to get to the dentist.
3. Ignorance - this age group grew up when the fundamentals of dental health were not stressed.
4. Anxieties or fear or both - about loss of

OBJECTIVE

PROCEDURES

teeth, about going to the dentist, or about having to wear dentures.

The dental services available to the elderly are, unfortunately, few and far between. Medicare benefits do not apply to dental services except in a few specific instances.

Community Resources

3. Identify resources in the community to solve specific nutritional health problems and life situations of the elderly.

The logical and reasonable question may arise, what resources in our community are available to solve all these nutritional problems, to meet the needs of the over 65 popluation?

There are no laws applicable to the nutritional needs of the older adult, even though all ages are protected by State and Federal laws regarding the safety of foods. The standard of nutritional requirements generally accepted in the United States is the "Recommended Dietary Allowances" set up by the Food and Nutrition Board of the National Academy of Sciences.

I am presently going to hand you an Info Sheet entitled "Resources to meet Nutritional Needs." Please take a minute or two to read through it now.

(Hand out Info Sheet #10.) After allowing about a minute for the class to read it, ask the following.)

What other resources are available in this county, for either information, education, or the provision of food or care? (Urge the participant to take notes again.)

Case Studies

4. Develop a proper two-day menu for an elderly client after identifying needs and matching resources to fulfill the need

Knowing and discussion of knowledge is one thing; the ability to use it practically and effectively is another.

I will now hand out four more Info Sheets:

Sheet #11 is "Case Studies and Instructions for Their Use"

Sheet #12 is "Nutrition Suggestions that May Make You Feel Better"

Sheet #13 is "Helping People Eat and Enjoy"

Sheet #14 is a "Daily Food Guide"

You also have Sheet #10, "Resources to Meet Nutritional Needs."

(Pair the class into groups of twos and assign each a number from 1 to 15. If there are more than 15 pairs, use triads. The number assigned is the case study number on Info Sheet #11.)

For the next 15-20 minutes, your dyad assignment is to:

1. Read your assigned case and the Info Sheets #11,12, 13 and 14.

2. Identify the food, nutrition, or eating problem or problems in the case.

3. Select the best set of resources, in your opinion, to solve the person's problems.

4. Be prepared to share with the class the reason (s) you chose that particular solution.

5. In addition, regardless of the solution you choose, I would also like you to plan a 2-day menu for that person using Info Sheet #14.

You may make reasonable assumptions which you deem necessary. Please note that there is no one correct answer. There are many ways to skin a cat.

(Call the group back together when most dyads are finished or within 20 minutes. Ask 3 or 4 dyads to first read to the group their case, and then share their definition of the problem, what solution they recommend and why they chose it, and read one day's complete menu.

(Thank each dyad which shares their solution and ask for comments from the class. This discussion should take about 20 minutes.)

OBJECTIVE

PROCEDURES

In summary, the need to modify food and eating habits among the elderly is significant. Select aspects of nutrition affect all older people, but the varied bio-psycho-cultural backgrounds of people - especially as they grow older -- require individualized approaches. To maintain good health, nutritional guidance is essential.

Session Seven will begin at _____ on _____ at _____. Thank you for joining us and we'll look forward to seeing you next session.

RESOURCES TO MEET NUTRITION NEEDS

I. Programs

A. Commodity Distribution Program

B. Food Stamp Plan

Both for low income persons supported by federal funds. available in N.C. as a supplement to provide assistance programs, not replace them.

C. Department of Agriculture
Food and Drug Administration
Public Health Service
Social Security Administration

Various programs pertinent to food and nutrition of older adults as well as other age groups.

D. American Dietetic Association
American Medical Association
American Dental Association
Better Business Bureau
Food and Nutrition Board
National Dairy Council

II. Nutrition Services

A. Reliable food information: educational materials and protection against unscrupulous companies and salesmen promising special foods and concoctions of nutrients to cure all kinds of ills.

1. Local health authorities

2. Food and Drug Division of State and Federal Health Department.

B. Reliable nutrition information: Nutrition specialist on staff of state or county Health Department.

1. State Nutrition Specialists are available for:

a. Professional in-service education

b. Assistance in developing training courses for professional and auxiliary groups

c. Assistance in developing the nutrition component of general health programs.

d. Assistance in planning nutrition programs, classes or food habits studies.

2. State Nutrition Specialists are resources for:

a. Reference material and bibliographies on all phases of nutrition

b. Samples and lists of reliable nutrition teaching aids and materials from different sources for use with various age and educational levels.

c. Supplies of reliable teaching materials, in limited quantities, for use with individuals or groups.

3. Area or Local Nutritionists would be available for the above functions and would have similar resources. In addition they could:

a. Give consultation on individual cases.

b. Assist in teaching classes.

c. Assist in setting up Commodity or Food Stamp Programs in the education of the recipients and the public.

4. The Federal Agricultural educational programs through Agricultural Extension Service based at the state universities.

5. Branch offices throughout each state have Home Economists who may be available to:

a. Cooperate in community nutrition programs.

b. Conduct classes for low income groups.

c. Train neighborhood leaders to conduct classes regarding best use of commodities and Food Stamps.

6. The Dairy Council: a cooperative educational organization supported by contributions from dairy producers and dealers, has branch offices in various parts of the state. Branch offices are staffed by nutritionists and health educators who are available to work in areas where local dairymen contribute support. They assist in nutrition education programs and they provide excellent free nutrition teaching materials for all ages.

C. Securing adequate food. Some state and local services make it possible for homebound older adults to secure food and provide stimulation of appetite and interest in food.

a. Meals-on-Wheels

b. Friendly visitors

c. Homemaker Service

d. County Social Service departments

III. Dental Resources

A. State and county health department clinics

B. Hospital out-patient clinics

C. Welfare payments, to be used for dental care under supervision of workers

D. Individual practitioners on a volunteer basis.

CASE STUDIES AND INSTRUCTION FOR THEIR USE

1. Read your assigned case and Information Sheets #12, 13, and 14.
2. In your case, identify the food, nutrition, and/or eating problem or problems.
3. Using Information Sheet #10 and your best knowledge, select the best set of resources to solve the problem(s) in your case.
4. Be prepared to share with the class the reasons you chose your particular solution or regimen.
5. In addition and regardless of the solution you choose, plan out 2-day's menues for that person using Information Sheet #14.

Note that there is no single correct answer; you are to choose one which, in your own opinion, is best. You may make any reasonable assumptions which you deem necessary.

ASSIGNMENT: Case Study #_____.

THE PROBLEMS (S) IS:

THE ALTERNATIVE RESOURCES WHICH I CAN RECOMMEND ARE:

1. 3.
2. 4.

THE SOLUTION I RECOMMEND IS:

BECAUSE:

COMPLETE DAILY MENUES			
	Breakfast	Lunch	Dinner
DAY 1			
Day 2			

Case I

Miss Smith is 80 years old, active and well but almost totally deaf. She has interests -- reading, nature watching, but almost no contact with people, partly because she can't hear, but also because her eccentric views and ways estrange others. Nobody knows how and what she eats because she has only 6 teeth, but she is seen going to and from the grocery store fairly often.

Case II

Mr. Johnson is 75 years old and lives alone since his wife died a few years ago. He is badly crippled with arthritis and has a tendency to become immobile because of the pain he endures. He dreads his weekly grocery shopping (a neighbor transport him) in the supermarkets where he must walk long distances. He seems satisfied with his meals which he prepares while sitting down. He longs for company although the attention of a good neighbor is fairly constant.

Case III

Miss Morris is 69 years old, the spinster daughter of immigrants from Newfoundland. The family was part of a tightly knit in-group who immigrated together. Miss Morris was over protected from childhood and since her parents' death, and the death of most of the group, she has been living in isolation. She was close to starving two years ago when she was persuaded to apply for state and federal aid. She is suffering from a neurological disease of the muscles that leaves her feeble and without strength. She insists that she is well and able to take care of herself - her great fear is of being sent to a nursing home. It is possible that her disease is due to malnutrition.

Case IV.

Mrs. Knight is an epileptic, 60 years old. She was able with medication to bring up two children, working without help from their father for their upkeep. Violent allergic reaction to her medication last year and failure to find an adequate substitute has made her liable to minor seizures which cause her to fall frequently with consequent injury to herself. She has become erratic, and so insatiable in her demands that her daughter who lives nearby is no longer allowed in her house to give her help she badly needs in shopping and preparing meals.

CASE V.

Mrs. Allen has lived alone for many years since her husband's death. Seventy years old now she believes that disliked teenagers in her neighborhood regularly come into her house during the night and destroy her belongings.

The evidence she shows is irrational and does not support her belief. Her only contact with people is by telephone. She has a group of cronies who call each other often, the gist of their conversations apparently being the exchange of "scare" information. For example: social workers only aim to dispose of your possessions and put you in an institution; doctors take your money, keep you waiting in their offices for hours, never do you any good; you're sure to die if you go to the hospital, even for x-rays, etc. Mrs. Allen is able to cook for herself she thinks, but information she gives about her food is not indicative of good nourishment.

Case VI.

James Wilson and his brother Tom live together. James, aged 75 had a severe heart attack last year but has recovered well and is fairly active. Tom is a diabetic, 69 years old, and has lost both of his legs. James shops and cooks for both of them but speaks darkly of going off to Florida, and of not being responsible for his brother. The state of the kitchen raises questions about the level of nutrition produced there.

Case VII.

John Brown, 78, who had a heart attack several years ago recently became a widower. He has been used to preparing his meals and his wife's since his wife was in failing health for some time. Now he is despondent and does not respond to the invitations of concerned neighbors to go with them to the Senior Citizen's Center where he could enjoy a variety of activities and companionship any afternoon. His reason for not going is his dog which he cannot leave alone because it would bark and distrub the neighbors close by. He says he thinks of giving his dog away if he could find someone who would give it a good home but he seems not to be able to take that action because the dog has long been a good companion to him and his wife who loved the dog.

Case VIII.

Laura Hanson, a widow of 75, lives next door in a mobile home park to Harry Lincoln, a widower of 74, and has for three years been a volunteer good neighbor, friend and housekeeper to him. They have all their meals together and she spends all the day in his home, presumably going to her home at night. Now her health is failing, she must give up this arrangement and will sell her mobile home and go live with her daughter in a town miles away. What will become of Harry who has become so dependent on Laura, and who has no children to help him? He is too dependent on women and committed to the old tradition that only women do housework; also that men need women as objects of men's domination to ever become halfway independent and a reasonable person. His mind is very keen and up to date on all other subjects such as the day's news, politics, managing his income, etc.

Case IX.

Mrs. Gaudette is 83 years old and French speaking. She has limited income and few social contacts because she is unable to speak English. She lives on the third floor, back apartment (single room and bath) of a run down housing project. The neighborhood is changing from French-Canadian to low-income rural families. Mrs. Gaudette is afraid to leave her room. In the past, she has relied on the local French speaking grocer to deliver her groceries. The grocery store, however, burned down four months ago. During your frequent visits with her, you have noticed that her dentures are always placed in a glass on the kitchen table.

Case X.

Mrs. Daily is 80 years old, and bound to a wheelchair by crippling arthritis. She lives on a second floor apartment and must maneuver five steps to get out of her apartment; consequently she doesn't get out very frequently. Living at home with Mrs. Daily is her 48 year old mentally retarded son. Her son is of very little assistance to his mother and is dependent on her to meet his needs. She will not leave the home without her son. She relies on neighbors to bring in groceries and prepares meals from a seated position in her wheelchair. Her apartment is not architecturally adapted for wheel chair mobility.

Case XI.

Mrs. Pisinski is a 85 year old widow who came from Poland to this country in 1910. She never speaks English in public and communicates with her family in Polish. She worked in the garment industry all her life and has an inadequate pension. Her children have moved to the suburbs and visit her only on Christmas and Easter. She prefers to eat Polish food but the local ethnic grocery moved to the suburbs. She has no car or public transportation available and her sight is failing rapidly.

Case XII.

Mr. Edwards is 65 years of age and recently retired. His wife has just died. He lived a full and active life and now he is alone. His children live on the West Coast. Mr. Edwards worked as a laborer for the Department of Public Highways. He receives a pension but his income is inadequate because his wages were always low. Mr. Edwards was well cared for by his wife. He never cooked a meal or shopped for food throughout their married life. His diet appears to consist almost entirely of peanut butter, not necessarily in a sandwich. When he laughs, as he often does, he frequently must readjust his dentures.

Case XIII.

Mrs. Rosen is 68 years old and has lived with a married daughter since her retirement at 62 from lifelong work as custodian in public buildings. She is cherished by her daughter who waits on her hand and foot. Mrs. Rosen has not been out of the house in several months. Her needs are met entirely by her

daughter and her family. She sees no one but her own family. With all this love and attention, she is despondent and perhaps seriously depressed.

Case XIV.

Mrs. Derkus is 78 years old and recently returned home from a long stay in the hospital. Prior to hospitalization she was able to get around and shop for herself. Since returning home her mobility is restricted; but she can get into a car with some assistance. She has no close relatives or friends. She had an unpleasant experience in the hospital related to the food served there. She is strongly opposed to eating food she has not cooked herself and is trying to survive on food stored in her refrigerator or on her shelves.

Case XV.

Mrs. Sanchez age 83, recently arrived from Puerto Rico. Shortly after her arrival her son and his family left her alone in a room in South Boston, to travel to New Hampshire to pick apples. Her son and his family are migrant workers. Mrs. Sanchez has money for one week's rent and only rice and beans to eat. She does not speak English and is afraid to venture out of her home as the neighborhood in which she lives is "rough." She is very suspicious of non-Spanish speaking individuals.

Nutrition Suggestions That May Make You Feel Better

1. Everyday exercise is best for maintaining both tone and appetite, but it need not lead to overeating. Try more walking.

2. Conquer any prejudice against good quality protein foods such as lean meat, fish, poultry, cottage cheese, low-fat milk, navy beans, or peanut butter.

3. Drink plenty of fruit juice or tomato juice.

4. Consume plenty of milk and dairy products.

5. Eat plenty of fresh, frozen, or canned fruits and vegetables.

6. Go easy on fats, fried foods, cream sauces and gravies.

7. Go easy on sweets, pies, cakes and candy; and as for bread, try enriched whole wheat, rye, or hot biscuits for variety.

8. Increase the variety of foods that you eat. The wider the variety of wholesome foods that you eat, the better the chances that you shall be well nourished.

9. Don't stuff yourself. Eat about the same amount at each meal. Try and eat your largest meal about noon.

10. Shun the promises of food fads and door-to-door peddlers of potions and pills.

11. Make a slight cut in total food intake if you are overweight.

12. Consume only moderate amounts of alcohol.

13. Become interested in nutrition and its relation to good health. Read the tips on nutrition which generally appear on the woman's page of your daily newspaper.

14. Have a routine annual checkup which includes a laboratory measurement of your blood and urine.

HELPING PEOPLE TO EAT AND ENJOY

A. Pleasant surroundings and companionship often tempt those with poor appetites.

1. Encourage all who are able to come to the dining area for meals.
2. Use tray services only when absolutely necessary.
3. Plan surprises, remembering birthdays and holidays.

B. Menus can be made more acceptable with careful planning.

1. Write menus preferably for the week ahead.
2. Plan in advance as far as possible to provide more interesting and acceptable meals.
3. Avoid repeating similar menus on identical days of the week.
4. Use foods in season to vary the menu.
5. Introduce only one new food at a meal.
6. Include familiar, well-liked foods often.
7. Permit a choice, if possible, at some time during the day.
8. Allow simple substitutions to increase satisfaction with and acceptability of the meals.

C. Well-prepared foods attractively served, will tempt residents to eat meals with greater enjoyment.

1. Season the food during preparation for all those on normal diets and for those on modified diets who are permitted seasonings.
2. Serve the menu as planned to all those residents who can have it.
3. Serve the special strained or chopped food only to those who cannot chew or to those whose diets require such foods.
4. Adapt the size of portions to the individuals.
5. Allow second portions to those who may have them and who desire them.

C.

6. Properly spaced meals allow development of appetite and increase satisfaction of residents. Meals should be served approximately 5 hours apart with not less than 10 hours between breakfast and a a substantial evening meal.

D. The following general information is pertinent to ALL diets:

1. All white bread and cereals should be enriched. Check the label.

2. All margarine should be fortified. Check the label.

3. If a low calorie salad dressing is purchased, check the label to avoid the use of a product containing mineral oil.

4. Liver should be included about once in ten days. It increases the iron, vitamin A, and the vitamins of the B complex in the menus.

5. All nonfat dry milk should be fortified with vitamins A and D.

6. That ethnic and cultural food patterns should be considered.

7. That meals served should be adapted, as far as possible, to likes and dislikes of the individual.

8. That menus should be varied as to color, texture and flavor.

DAILY FOOD GUIDE

GROUP	FOOD INCLUDED	AMOUNT RECOMMENDED
Milk	Whole, skim, dry*, evaporated*, buttermilk	Adults -- 2 cups daily (1 pint)
Meat, Poultry, Fish	Beef, veal, lamb, pork, variety meats as liver, heart, kidney, poultry, fish and shellfish	2 or more servings daily (total of 4-6 ounces, boneless, lean cooked meat, poultry or fish)
Eggs		4-7 per week (1 may be used as substitute for 1 ounce of meat)
Cheese	Any kind	(1 ounce may be used as substitute for 1 ounce of meat)
Legumes and nuts	Dry beans, peas, lentils, peanut butter, nuts	May be used occasionally (1/2 cup cooked dry beans or peas or 1 ounce of peanut butter may be used as substitute for 2 tablespoons of meat)
Vegetables and Fruits	All vegetables, including potatoes	2 or more servings daily (1/2 cup each)
	** Deep yellow fruits or vegetables, or dark green leafy vegetables; apricots, cantaloupe; sweet potato, carrots, winter squash, pumpkin, broccoli, chard, collards, kale, spinach, turnip greens, escarole, chicory, and other dark green leaves	(Include 1 serving at least every other day)
	All fruits, including citrus daily	2 or more servings daily --at least one citrus
	***Citrus fruits such as orange or grapefruit or their juices, or tomatoes	1 orange, or 1/2 grapefruit, or 1/2 cup juice, or Use twice as much tomatoes
Breads and Cereals	All breads and cereals, whole grain enriched, or restored	4 servings or more

Include other foods as fats and sweets or additional servings of foods listed to provide adequate calories.

*Reconstituted; ** Vitamin A rich foods; *** Vitamin C rich foods.

This diet provides approximately 80 grams of protein and 2,000 calories, Minerals and vitamins meet the standards for the Recommended Dietary Allowances of the Food and Nutrition Board of the National Research Council.

TIME AND LEISURE

PURPOSE:

To develop within each participant an understanding and attitude concerning leisure activity of the aging person and its relationship to health maintenance.

OBJECTIVES:

At the completion of this session, the participant will be able to:

1. Discuss the relationship between leisure in retirement and good health.
2. Discuss the involvement of social attitudes toward leisure.
3. List the objectives of a leisure program for the aging.
4. Identify program alternatives which meet the objectives of a good leisure program.

TIME:

About 1 3/4 hours

MATERIALS NEEDED:

A. Blackboard or flip charts and felt pens

B. Information Sheet #15, "Objectives of Leisure Programs"

C. 16 mm film projector and screen

D. Two movies

1. "The Art of Age", 27 minutes, color, 1972.
2. "Rescue from Isolation", 22 minutes, color, 1972.

OBJECTIVE

1. Discuss the relationship between leisure in retirement and good health

PROCEDURES

Good morning/afternoon. This session in the series of "Maintaining" Good Health in Late Life" is aimed at understanding the abundant factor in most older people's lifetime. .

Seven year old Eric Christopher doesn't have enough of it; there are too many things for him to do outside and he can't quite seem to fit them all in before bedtime. His mother seems to have too little time also. She works from 9 to 4 in addition to caring for her family of four, and making the Christopher house a home. Mr. Christopher spends 9 to 11 hours each day in work that he very much enjoys; his weekends are full too, because of the part-time job he holds to make financial ends meet and the lawn work. Gramma Christopher, age 74, lives about 10 miles away in a small but need-fulfilling apartment. It would seem to Eric and his parents that Gramma Christopher has nothing but time since Grampa Christopher passed away five years ago. And since Gramma doesn't work, the fact of the matter is that she has 24 hours a day of free time for whatever she chooses.

If Gramma Christopher is typical of most people her age, what in your opinion would she do with that 24 hours on a typical day? What kind of activities fill the day of a typical person over 65 years?

(List participant answers on the blackboard.)

Sleep	8 hours
Food preparation	2 hours
Housekeeping	1 1/2 hours
Phone	1 hour
Shopping	1 hour
	13 1/2 hours

Ask what she would typically do with the remaining 10½ hours? What do elderly people do with their leisure?

ANSWER: Some find satisfaction in retirement community amusements. Others stay in old communities and find satisfaction in civic, church, adult education clubs, senior citizens organization and other activities. However, relatively few older people participate actively. Studies indicate that

OBJECTIVE

PROCEDURES

Visiting
Reading magazines and newspaper
Watching T.V.
Gardening and Sewing

are the activities in which most older people commonly engage. The majority seem to increase their involvement in earlier roles and do not develop new ones.)

Is there a relationship between our definitions of health and that 10½ hours of leisure time? How does leisure time and activity, or the lack of activity, affect the health of the older person?

(ANSWER: It is a key in the morale and self-image. It is also an important contributory factor to promoting physical health. There is a very strong relationship between good health, both mental and physical, and active living.)

Involvement of Attitude Toward Leisure

2. Discuss the involvement of social attitudes toward leisure.

With ours being a work-oriented culture, leisure is considered not only as free time, as contrasted with work, but also as time which has been earned. For the retired person, all time may be considered as being paid for by the many previous years of work.

Do you think Gramma Christopher views leisure in this way? Why?

(ANSWER: Probably not. Realistically, she is faced with conflicts as to the use of time because of the historical conception of non-work activity. That conception stated that leisure is wasteful, sinful, and to be avoided. Puritan theology has permeated several hundred years of our existance and places emphasis on work as living necessary for divine salvation.

Another possible conflict, reinforced by the major immigration periods of the 19th and 20th centuries, is that leisure is honorable but only as a restorative for work.

OBJECTIVE

PROCEDURES

A third conflict for Gramma concerns motivation for work. In addition to sustenance needs, work became increasingly related to emotional and psychological needs. One's conception of self became centered in the job.

The conflicts that Gramma and all her contemporaries face, then, deal with the traditional conception of leisure as utilitarian. Leisure was a release from work obligations but chiefly to those activities which refresh oneself again for more work.)

Do you agree with the traditional concept of leisure? How do you view leisure? Is it a freedom to act?

(The five minute discussion here should be directed toward the emerging attitude that leisure is not subordinate to work. Leisure is to be looked upon as a worthwhile goal in itself, not a means to the goal of work.)

Objectives of a Leisure Program

3. List the objectives of a leisure program for the aging.

Let's suppose for a moment that you have just suggested bridge, rolling bandages, singing, selling a hobbycraft item, golf, or other such activities to Gramma Christopher or her friend down the hall, 81 years old Mr. Springer.

1. "What the use, since I'm now too old."

2. "I don't have enough money."

3. "My health is too bad."

What tack would you take in answer to these comments?

(Ask 2 or 3 participants for their response to these comments. Then suggest that programs for use of leisure time are aimed by dispelling the attitude of "I'm too old", at offsetting the deadening effects of loneliness, and at replacing declining physical health with increased efficient use of remaining capacities.) These and other aims are precisely the goals and objective of leisure programs and counseling.

OBJECTIVE	PROCEDURES
	Information Sheet #15, which I am about to distribute to you, lists these objectives and others pertinent to the use of leisure time activities for our aging population. (Distribute Info Sheet #15 and ask the participants to read it. Allow 1 or 2 minutes.) What role or relationship do you see in these objectives that tie to health needs and maintenance? (In answer to this question, lead a ten minutes discussion concerning the emotional well-being as a part of psychological health and its ties to physical health. You might include the maxim, "You are as old as you think or feel".
	Alternatives to Vegetation of the Older Person
4. Identify program alternatives which meet the objectives of a good leisure program	We could develop another list now, one listing a number of leisure activities and discuss their applicability to psycho-social health and well-being. Let's take another direction, though, let's evaluate ongoing program alternatives for the aging in light of the objectives on Info Sheet #15. I'm going to show you two very interesting and excellent films on alternatives to vegetation of the older person. I would like you to evaluate the programs depicted in each film against our objectives. For each program or activity, does it adequately meet the objectives listed on the [illegible] sheet? Please mark your evaluation as yes or The first film is titled "The Art of Age" and profiles the lives of four elderly people, our "leisure programs" in this instance. Watch how each has developed his or her own "program" and what needs it fulfills within the persons. (Show film "The Art of Age", 27 minutes, color, 1972) (While placing the second film on the projector, ask the group for their comments and observation Also ask 1 or 2 participants for a 10 word synopsis of the film. Your synopsis might be:

A. "One is under an obligation to live as long as one is living."

B. Each year of life means increased wisdom and knowledge; growth and learning need never stop.

C. Busy hands and active minds, minds which share positive thoughts of new beginnings.)

Not all elderly people can be as active as the four to whom we were just introduced. Real physical and mental illness can handicap many older persons. This film, "Rescue from Isolation" documents the alternative programs for those who are not motivated or physically able to take advantage of community resources and preserts an answer in the institutional form of a psycho-geriatric day hospital. The setting is Montreal, Canada.

(Show film "Rescue from Isolation, 22 minutes, color, 1972.)

(When film is completed, ask 2 or 3 participants)

What is your overall evaluation of the leisure time programs we just saw?

What lessons did you see that you can begin to apply here in North Carolina?

This completes Session Seven. Thank you for your participation. In preparation for the next and final session in this series, I would like 10 minutes of your time between now and then. I would like each of you to write out on paper a question for the group, a question dealing with "Maintaining Good Health in Late Life", a question whose answer you would like others in the group to answer for you, one to which you don't know the answer.

Session Eight will begin at _____ on _____ at _____ _____. See you then.

Objectives of Leisure Programs

	Leisure Program											
	1	2	3	4	5	6	7	8	9	10	11	12
1. Dispell attitude of "I'm too old"												
2. Offset effects of aloneness and loneliness												
3. Parry consequences of reduced income												
4. Companionship and fun												
5. A sense of belonging to the community												
6. A feeling of contentment												
7. Opportunity to receive recognition												
8. Outlet to develop new interests and skills and retain or renew old ones.												
9. Occasion for both continuous learning experience and arousing interest to stimulate learning.												
10. Assistance to adjust in a changing environment.												

DEMISE AND REPRISE

PURPOSE: To develop and foster in the participant an understanding and positive attitude about the older person's view of death; to provide a meaningful cross-cultural summary of the seminar series and a motivational stimulus for the participant's future work with the aging.

OBJECTIVES: At the conclusion of this seminar, the participant will be able to:

1. Effectively provide a personal synopsis of this seminar series. (25 minutes)
2. Discuss and compare his attitude and those of the aging toward death. (45 minutes)
3. Compare and contrast cultures other than American in challenging and changing Western aging stereotypes. (60 minutes)

TIME: About 2 1/4 hours.

MATERIALS NEEDED:

A. Blackboard or flip charts with felt pens.

B. 16 mm movie projector and screen.

C. Movies

1. "Until I Die", 30 minutes, color.
2. "The Family of Man: Old Age", 45 minutes, color.

D. Information Sheet #16, "A Positive Living Program for Senior Citizens".

OBJECTIVE

PROCEDURE

Good morning/afternoon. This session is our final in the series on "Maintaining Good Health in Late Life". Before we proceed with the material to be covered today, let's begin with a recap of the series by discussing the questions I asked you to develop at the conclusion of Session Seven.

(Ask for volunteers to share their questions with the group, and have the group respond with their answers. You will want to summarize or state the concensus to each question posed. Allow about 15-20 minutes. If no one responds or after the questions, ask the following question:)

1. Effectively provide a synopsis of this seminar series.

In your own words, how would you summarize this series of seminars from the stand point of how does a person in late life maintain good health? What are the key factors in maintaining, or even improving, health in our definitions?

(Ask 2 or 3 people to share their personal summary. Then in your own words, give a brief (1 minute) summary of the series' material. You will probably want to prepare this personal statement before the session.)

Demise

2. Discuss and compare one's own attitude and those of the aging toward death.

The ultimate and inescapable fact of life is its end, death. Each of us holds a view of that event which is personal, real, and meaningful. I would like you to share that view with the other participants in a quick attitudinal survey.

(Using either a show of hands or a paper ballot, ask the group to respond to the following question by a response of

1. Yes
2. No
3. No, with qualifications.)

Are you afraid to die?

(On the blackboard, draw the following chart.)

OBJECTIVE

PROCEDURE

	Our Group	Elderly Survey
Yes		
No		
No with quals.		

Tally the group response, and then place the figures 10%, 35%, and 55% in the "Elderly Survey" column on the board.

Point out the difference or similarity in attitudes between your age group and that of an actual survey...)

These percentages reflect a study of 269 people 60 years of age or older. During a 2-day examination, this question, "Are you afraid of dying", was asked. The 55% who responded "No with qualifications" said:

- No, but it is inevitable - 17%
- Mixed feeling - 16%
- No, but want to live as long as possible - 13%
- No, but do not wish to be sick a long time - 4%
- No, but dread the pain of dying - 2%

Thus, some 85% of the older respondents said, they were not afraid to die. On the whole, then, the aging American has dealt with death as a fact of life, more so than those persons under age 60. Of course, this is somewhat natural since they are closer to their demise than a 30 year old. The point that I want to make is that most elderly people do not fear death as we generally think they do.

In our work situation with the older person, it is imperative that our views of death not cause anxiety in our clients.

Dr. Elizabeth Kubler-Ross has done some very excellent work in this subject area, which is examined in the film we are about to see.

OBJECTIVE

PROCEDURE

I would like you to make notes on the 5 states and your other observations during the film for discussion afterwards.

(Show film, "Until I Die", 30 minutes)

(Open a 10 minute discussion of the film by asking the following question.)

Which person's attitude as shown in the film was most healthy in your opinion? Why?

(It will probably be difficult to limit the discussion to 10 minutes.)

Positive Alternatives Toward Growing Old

3. Compare and contrast cultures other than American in challenging and changing Western aging stereotypes.

We Americans often tend to miss opportunities for personal growth found in other than our own culture. And yet, people all over the world grow old, facing the problems of age and finding solutions. Life in England, New Guinea, and the Himalayas have rituals, philosophies, duties, problems, and places in the hierarchy of family and society. I think that you will find many positive challenges to our Western aging stereotypes in this next film.

You have no doubt noticed during this entire series of seminars, the positive attitude we have endeavored to foster toward growing old and remaining physically and especially mentally healty. I would like to distribute now, in preparation for this unique film experience, what we will call a "Positive Living Program for Senior Citizens". I will wait a minute of so before beginning the film to let you read and absorb these recommendations. Although these points are typically American in nature, see if you can add to them from the cultures shown in the film.

(Distribute Information Sheet #16. Wait about 1-2 minutes before starting the film, "The Family of Man: Old Age", 45 minutes.)

(Lead a 10-15 minute discussion about the film around the following questions.)

OBJECTIVE

PROCEDURE

1. What similarities of the aging processes with respect to health did you observe in the 5 geographical locations?

2. What were the differences? Were they positive or negative differences?

3. What positive points for living did you add to Information Sheet #16?

4. What role did maintaining good health play in the lives of people in other nations?

5. How will you begin to apply some of the new ideas you have been introduced to in your work situation?

6. Has this film or this series of seminars changed your views about growing old and/or working with older people?

This concludes the seminar series on "Maintaining Good Health in Late Life". Thank you for coming and sharing your views with us. I trust that each of you has enjoyed and learned from this seminar experience as much as I have learned and enjoyed being with you.

A POSITIVE LIVING PROGRAM FOR SENIOR CITIZENS

1. Take a humorous view of things.
2. Cultivate extrovert activities.
3. Do some writing every day.
4. Develop the gustatory sense.
5. Read good books.
6. Pay more attention to dress.
7. Keep in touch with athletics.
8. Modify ambitious desires.
9. Do some manual work each day.
10. Watch political developments.
11. Attend church services or activities.
12. Walk buoyantly and sit erect.
13. Come to the point quickly in conversation and avoid repetition.
14. Try to converse in an interesting and stimulating manner in order to interest others; forget the past and focus on the present and future.
15. Keep as serene a countenance as possible.
16. Be thoroughly masculine or feminine.
17. Try to help others each day.
18. Be attractive to young persons of both sexes.
19. Secure plenty of rest but keep active.
20. Act as though life will continue for one hundred years.
21. Have an objective in life.
22. Above all, remember that, after middle life, happiness must be sought.
23.
24.
25.
26.

Bibliographic and Other Information Sources

In the last decade, the literature in the field of gerontology has grown exponentially. Any library, public or private, will have vast amounts of literature on the subject of the older American covered in this manual, in addition to extensive bibliographies, some annotated. Thus, it would be fruitless and redundant for us to attempt to list them here.

However, the following select list will give you an entry to that literature and other sources of information in the field of aging. Once again, we stress your thorough reading of the Department of Health, Education and Welfare series, Working With Older People, 4 vols.

Books

Atchley, R. C. The Social Forces in Later Life: An Introduction to Social Gerentology. Belmont, California: Wadsworth Publishing Company, Inc., 1972.

Butler, R. N., and Lewis, M. I. Aging and Mental Health: Positive Psychological Approaches. St. Louis: C. V. Mosby Company, 1973.

Cowdry, E. V., and Steinberg, F. U. The Care of the Geriatric Patient. St. Louis: C. V. Mosby Company, 1971.

Douglas-Wilson, I., and McLachlan, G., ed. Health Service Prospects: An International Survey. Boston: Little, Brown and Company, 1973.

Duke University Medical Center Library. Keyword Index to Training Resources in Aging. Durham: Duke University, 1975.

Governor's Council on Aging. Social Indicators for the Aged: A Report on the Survey of Needs, 1971-72. Raleigh, North Carolina Department of Human Resources, 1973.

Kubler-Ross, E. On Death and Dying. New York: MacMillian Company, 1969.

National Council on the Aging. The Golden Years...A Tarnished Myth. New York: National Council on the Aging, Inc., 1970.

Osterbind, G. C. Income in Retirement: The Need and Society's Responsibility. Gainsville: University of Florida Press, 1967.

Pastalon, L. A., and Carson, D. H., ed. Spatial Behavior of Older People. Ann Arbor: University of Michigan, 1970.

Percy, C. H. Growing Old in the Country of the Young. New York: McGraw-Hill Book Company, 1974.

Pfeiffer, E. Alternatives to Institutional Care for Older Americans: Practice and Planning. Durham: Duke University, 1973.

Powell, J. Why Am I Afraid to Tell You Who I Am? Niles, Illinois: Argus Communications, 1971.

Bibliographic and Other Information Sources, Continued

U. S. Department of Health, Education and Welfare. Planning Welfare Services for Older People. Washington, D. C.: Government Printing Office, 1965.

Holter, P. Guide to Retirement Living. New York: Rand McNally, 1973.

Assistance and Resources

GENERAL

1. Administration on Aging
   Office of Human Development
   D.H.E.W.
   Washington, D. C.

2. National Council on the Aging
   1828 L Street, N.W.
   Washington, D. C. 20036

3. U. S. Senate Special Committee on Aging
   Room 6 - 233, New Senate Office Building
   Washington, D. C. 20510

4. N. C. Governor's Coordinating Council on Aging
   213 Hillsborough Street
   Raleigh, N. C. 27603

5. Center for the Study of Aging and Human Development
   Duke University Medical Center
   P. O. Box 3003
   Durham, N. C. 27710

6. Ethel Percy Andrus Gerontology Center
   University of Southern California
   University Park
   Los Angeles, California 90007

7. Institute of Gerontology
   The University of Michigan
   543 Church Street
   Ann Arbor, Michigan 48104

8. Center for Studies in Aging
   North Texas State University
   c/o Librarian
   Denton, Texas

9. Oregon Center for Gerontology
   1597 Agate Street
   Eugene, Oregon 97403

Bibliographic and Other Information Sources, Continued

FINANCIAL ASSISTANCE

10. Local Social Security office

11. Local Bureau of Internal Revenue office

12. Local Veterans Administration office

LEGAL ASSISTANCE

13. The North Carolina State Bar
Justice Building
Raleigh, N. C. 27611
(919) 832-0518

14. National Senior Citizens Law Center
1709 West 8th Street
Los Angeles, California

HEALTH CARE ASSISTANCE

15. Local Social Security office

16. Local Welfare office

17. About Health Maintenance Organizations in your area:
Group Health Association of America
1717 Massachusetts Avenue, N.W.
Washington, D. C. 20036

HOME PLANNING ASSISTANCE

18. Local H.U.D. office, or
U. S. Department of Housing and Urban Development
Washington, D. C. 20250

19. Farmer's Home Administration
U. S. Department of Agriculture
Washington, D. C. 20250

AGE DISCRIMINATION IN EMPLOYMENT

20. Local office of the U. S. Department of Labor, Wage & Hour Division
Or
U. S. Department of Labor
Wage and Hour Division
Washington, D. C. 20210

OTHER HELP AND ASSISTANCE

21. Local newspaper "action line"

22. Call for Action
Raleigh/Durham, (919) 832-7578 WRAL-TV

OTHER HELP AND ASSISTANCE, Continued

23. Retired Professionals Action Group
200 P Street
Washington, D. C. 20036

24. Gray Panthers
3700 Chestnut Street
Philadelphia, Pennsylvania 19104

25. National Council on Senior Citizens
1511 K Street, N.W.
Washington, D. C. 20036

26. Senior Advocates International
1825 K Street
Washington, D. C. 20006

27. National Association of Retired Federal Employees
1909 Q Street
Washington, D. C. 20009

WORK ALTERNATIVES

28. Foster Grandparents Program (pay)

29. Volunteers in Service to America (pay) VISTA

30. Peace Corps

(28-30) c/o ACTION
Washington, D. C. 20525

31. Green Thumb, Inc. (pay)
1012 14th Street, N.W.
Washington, D. C. 20005

32. Senior Aides (pay)
National Council of Senior Citizens
1511 K Street, N.W.
Washington, D. C. 20005

33. Senior Community Service Project (pay)
National Council on the Aging
1828 L Street, N.W.
Washington, D. C. 20036

34. NRTA-AARP Senior Community Aides (pay)
National Retired Teachers Association/
American Association for Retired Persons
1909 K Street, N.W.
Washington, D. C. 20006

WORK ALTERNATIVES, Continued

35. Bureau of Census Interviewers (pay)
Bureau of Census
U. S. Department of Commerce
Washington, D. C. 20233

36. State employment

37. Labor unions

38. Local senior centers

39. Health and welfare councils

40. Federal Job Information Center

(36-40) (Yellow pages)

NON-PAY OPPORTUNITIES

41. V. A. hospitals

42. Public and private hospitals

43. Savings Bond "Salesmen"
Coordinator of Volunteer Activities
Saving Bond Division
U. S. Department of the Treasury
Washington, D. C. 20220

44. Community action programs
Office of Economic Opportunity
Washington, D. C. 20506

45. Local Board of Education, or
National Affiliation for Literacy Advance
1011 Harrison Street
P. O. Box 131
Syracuse, New York 13210

46. Service Corps of Retired Executives (SCORE)

47. Active Corps of Executives (ACE)

48. Retired Senior Volunteers Program (RSVP)

(46-48) c/o ACTION
Washington, D. C. 20525

49. National Center for Voluntary Action
1625 Massachusetts Avenue, N.W.
Washington, D. C. 20336

PUBLICATIONS TO ORDER

1. Local Social Security office:

"Estimating Your Social Security Retirement Check"
"If You Become Disabled"
"Your Medicare Handbook"

2. Local IRS office:

IRS Pub. No. 554, "Tax Benefits for Older Americans"
IRS Pub. No. 533, "Information on Self-Employment Tax"
IRS Pub. No. 531, "Reporting Your Tips for Federal Purposes"
IRS Pub. No. 559, "Federal Tax Guide for Survivors, Executors, and Administrators"

3. Local Veterans Administration office:

"Federal Benefits for Veterans and Dependents"

4. Administration on Aging, U. S. D.H.E.W., Washington, D. C. 20201

"Are You Planning on Living the Rest of Your Life?"
"Employment and Volunteer Opportunities for Older People"
"To Find the Way, Guidelines for a Telephone Reassurance Service"
"Project Helping Wheels"
"You, the Law and Retirement"

5. Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402.

To get on the catalog mailing list, write to the above -- attention of "S. L. Mail List".

Working With Older People series	
Vol. 1: The Practitioner and the Elderly	$1.00
Vol. 2: Biological, Psychological and Sociological Aspects of Aging	1.00
Vol. 3: The Aging Person: Needs and Services	1.00
Vol. 4: Clinical Aspects of Aging	1.00
Medicare...Medicaid: Which is Which?	.40
Nursing Home Care	.40
Food Guide for Older Folks	.30
Family Food Budgeting	.15
Back to Work After Retirement	.85
Family Food Buying	.70
Helping Families Manage Their Finances	.95
Make Each Person Count	.55
Home Health Services in the U. S.	1.30
Information and Referral Centers: A Functional Analysis	1.10
Information Giving and Referral	1.45